All Florida Orthopaedic Associates

Patient Registration Form

Date _____

PATIENT INFORMATION ***(Please Print)***

Patient Name (Last Name, First Name, Middle Initial)		Social Security Number	Age
Present Address	City	State	Zip Code
Permanent Address	City	State	Zip Code
Patient Phone Number ( )	Work Phone Number ( )	Patient Birth Date ____/____/____	Patient Sex ___Male ___Female
E-Mail Address	Guardian/Emergency Contact Name (Name, Address and Phone Number)		
Primary Care Physician Name and Address		Physician Phone Number ( )	

Is your injury related to:
(Check One) Employment Accident? _____ Auto Accident? _____ Slip and Fall? _____
Other? Explain: _____
Date of Injury: ____/____/____

Employer Name and Address		
Employer Phone	Occupation	Employer Contact Name

* **Parents of children under the age of 18 must accompany their child to each doctor's appointment. Children are not to be left unattended by an adult in the waiting room.**

INSURANCE INFORMATION ***(Please Print)***

Primary Insurance Company		Insurance Telephone Number	
Address	City	State	Zip Code
Name of Insured	Insured Birth Date / /	Insured Social Security #	Relationship to Patient
Address	City	State	Zip Code
Insurance ID Number	Group Number	Type of Insurance	
Secondary Insurance Company		Insurance Telephone Number	
Address	City	State	Zip Code
Name of Insured	Insured Birth Date ____/____/____	Insured Social Security #	Relationship to Patient
Address	City	State	Zip Code
Insurance ID Number	Group Number	Type of Insurance	

To the best of my knowledge, all information is correct. I acknowledge that I am ultimately responsible for payment of my account with All Florida Orthopaedic Associates. Workers' Compensation patients with proper authorization are exempt from financial responsibility.

Patient Name (Please Print) _____ Date _____

Patient Signature _____

All Florida
Orthopaedic
Associates

Patient Authorization Form

Patient Name (Please Print) _____ Patient Account Number _____

AUTHORIZATION TO RELEASE INFORMATION

Please accept this document as authorization to physicians, hospital medical attendants, employers, records custodians, insurance carriers, and my attorney to furnish full and complete medical records, reports, and x-rays. Further, this authorization is intended to include any psychiatric, psychological, HIV, drug, and alcohol information. Also, confidential patient information may be accessed by employees of designated providers for the purpose of photocopying the information in response to properly authorized requests for copies of medical records. These designated providers are bound by the same confidentiality requirements as are employees of All Florida Orthopaedic Associates.

AUTHORIZATION TO RELEASE INFORMATION – SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to All Florida Orthopaedic Associates ("AFO") for any services furnished to me by any AFO provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent or to my Medigap Insurer (if applicable) any information needed to determine these benefits for related services.

AUTHORIZATION FOR TREATMENT

I hereby authorize the medical staff of AFO to render medical services as deemed necessary.

FINANCIAL AGREEMENT

I understand that I am financially responsible for services rendered by Drs. Robert G. Hamilton, Lawrence M. Gnage, Brett R. Bolhofner, Clinton B. Davis, Jorge A. Rodriguez, Jr., William E. Lowry, Kanta C. Shah, George H. Canizares, Robert L. Swiggett, Matthew J. Swick, Adrian M. Butler, Kurt C. Hirshorn, Stephen C. Anderson, Matthew D. Cusumano, Jeffrey D. Kopelman, and Jennifer M. Burns and their staff. Payment will be made by insurance assignment, me and/or my authorized guarantor.

AUTHORIZATION OF PAYMENT

I hereby authorize payment of medical benefits to be made directly to AFO by my insurance carrier(s), and if appropriate, request payment of governmental benefits directly to AFO.

HIPAA PRIVACY NOTICE

I hereby acknowledge that I have been offered a copy of AFO's Notice of Privacy Practices.

Patient Signature _____ Date _____

HISTORY OF PRESENT ILLNESS

What is your Chief Complaint (main reason you came to see the doctor)?

_____

Side

☐ Right ☐ Left ☐ Both

Level of Pain

☐ Mild ☐ Moderate ☐ Severe

When did the symptoms start?

Were you injured? ☐ Yes ☐ No
If yes, how did it happen?

Have you seen a physician for this? ☐ Yes ☐ No
If yes, what treatment(s) did you have?

Have x-rays been taken? ☐ Yes ☐ No
If yes, where?

Do you have any allergies to medications? ☐ Yes ☐ No
If yes, please list:

Are you currently taking any medications? ☐ Yes ☐ No
If yes, please list:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Pharmacy used: _____

_____

Have you ever had a reaction to anesthesia? ☐ Yes ☐ No
If yes, explain:

Medical History

Have you ever been diagnosed and/or treated for any of the following?

Must Circle Yes or N			Notes	Must Circle Yes or No			Notes
Allergies	Yes	No		Hernia	Yes	No	
Anemia	Yes	No		High Cholesterol	Yes	No	
Anxiety Disorder	Yes	No		Hypertension	Yes	No	
Arthritis	Yes	No		Hypothyroidism	Yes	No	
Artificial Joints	Yes	No		Kidney Disease	Yes	No	
Asthma	Yes	No		Kidney Stones	Yes	No	
Back Pain	Yes	No		Leg or Foot Ulcers	Yes	No	
Bleeding Disorder	Yes	No		Lung Disease	Yes	No	
Blood Clots	Yes	No		Migraines	Yes	No	
COPD	Yes	No		Muscle, Joint, or Bone Problems	Yes	No	
Cancer	Yes	No		Neck Injury	Yes	No	
Carpel Tunnel	Yes	No		Neurologic Disorder	Yes	No	
Cataract	Yes	No		Neuropathy	Yes	No	
Chronic Sinus/Rhinitis	Yes	No		Obesity	Yes	No	
Coronary Artery Disease	Yes	No		Organ Transplant	Yes	No	
Depression	Yes	No		Osteoporosis	Yes	No	
Diabetes	Yes	No		Pacemaker	Yes	No	
Dialysis	Yes	No		Peripheral Vascular Disease	Yes	No	
Edema	Yes	No		Polio	Yes	No	
Emphysema	Yes	No		Pulmonary Embolism	Yes	No	
Fibromyalgia	Yes	No		Rheumatoid Arthritis	Yes	No	
Foot Deformity	Yes	No		Scoliosis	Yes	No	
Fractures	Yes	No		Seizures/Epilepsy	Yes	No	
Frost Bite	Yes	No		Serious Illness or Injuries	Yes	No	
GERD/Reflux	Yes	No		Sleep Apnea	Yes	No	
Gallbladder Disease	Yes	No		Spinal Stenosis	Yes	No	
Gout	Yes	No		Stroke	Yes	No	
HIV or AIDS	Yes	No		Substance Abuse/Alcohol	Yes	No	
Head Trauma/Injury	Yes	No		Tuberculosis	Yes	No	
Headaches or Migraines	Yes	No		Ulcers	Yes	No	
Heart Attack (MI)	Yes	No		Urinary Tract Infection	Yes	No	
Heart Disease	Yes	No		Varicose Veins	Yes	No	
Heart Problems	Yes	No			Yes	No	
Hepatitis	Yes	No					

Past Surgical History

Have you ever had any of the following surgeries?

	Date		Date		Date		Date
☐ ACL Surgery	__/__/__	☐ CABG	__/__/__	☐ Hernia Repair	__/__/__	☐ Tonsillectomy	__/__/__
☐ Angioplasty	__/__/__	☐ Carpal Tunnel Release	__/__/__	☐ Hip Replacement	__/__/__	☐ Valve Replacement	__/__/__
☐ Angio w/ Stent	__/__/__	☐ Cataract Extraction	__/__/__	☐ Knee Replacement	__/__/__	**Gender Specific**	
☐ Appendectomy	__/__/__	☐ Cholecystectomy	__/__/__	☐ Pacemaker	__/__/__	☐ Cesarean Section	__/__/__
☐ Arthroscopy _____	__/__/__	☐ Gall Bladder Removal	__/__/__	☐ Rotator Cuff Repair	__/__/__	☐ Hysterectomy	__/__/__
☐ Back Surgery	__/__/__	☐ Gastric Bypass	__/__/__	☐ Thyroidectomy	__/__/__	☐ Mastectomy	__/__/__
☐ Past Fractures		_____	__/__/__	_____	__/__/__	_____	__/__/__

Family History

Have any family members ever been diagnosed and/or treated for any of the following? If so, what age were they?

	Mother	Father	Sister	Brother		Mother	Father	Sister	Brother
Diagnosis	**Age Onset/ Death**	**Age Onset/ Death**	**Age Onset/ Death**	**Age Onset/ Death**	**Diagnosis**	**Age Onset/ Death**	**Age Onset/ Death**	**Age Onset/ Death**	**Age Onset/ Death**
Alive and Well	☐ ____	☐ ____	☐ ____	☐ ____	Drug Abuse	☐ ____	☐ ____	☐ ____	☐ ____
Alcoholism	☐ ____	☐ ____	☐ ____	☐ ____	Gout	☐ ____	☐ ____	☐ ____	☐ ____
Alzheimer's Disease	☐ ____	☐ ____	☐ ____	☐ ____	Heart Disease	☐ ____	☐ ____	☐ ____	☐ ____
Arthritis	☐ ____	☐ ____	☐ ____	☐ ____	Hypertension	☐ ____	☐ ____	☐ ____	☐ ____
Blood Disease	☐ ____	☐ ____	☐ ____	☐ ____	Kidney Disease	☐ ____	☐ ____	☐ ____	☐ ____
Cancer	☐ ____	☐ ____	☐ ____	☐ ____	Liver Disease	☐ ____	☐ ____	☐ ____	☐ ____
COPD	☐ ____	☐ ____	☐ ____	☐ ____	Mental Illness	☐ ____	☐ ____	☐ ____	☐ ____
CVA (Stroke)	☐ ____	☐ ____	☐ ____	☐ ____	Obesity	☐ ____	☐ ____	☐ ____	☐ ____
Depression	☐ ____	☐ ____	☐ ____	☐ ____	Other _____	☐ ____	☐ ____	☐ ____	☐ ____
Diabetes	☐ ____	☐ ____	☐ ____	☐ ____					

Language

Primary Language Spoken	Primary Language Spoken at Home
Birthplace	

Social History

	Please Circle	Notes
Education		
Occupation		
Occupational health risks		
General stress level	Low / Med / High	
Marital status	S / M / D / W	
Live alone or with others?	Alone / Others	
Single or multi-level home/work?	Single / Multi	
Smoking Status	Never/Former/Current Every Day	
Smoking - How much?		
Has smoked since age		
Alcohol intake	Occasional / Moderate / Heavy	
Caffeine intake	Occasional / Moderate / Heavy	
Illicit drugs		
Exercise level	Occasional / Moderate / Heavy	
Sporting activities		
Seat belts used routinely	Y / N	
Advance directive	Y / N	
Chewing tobacco	1DAY / 2-4DAY / 5+DAY	
Number of children		
Hand Dominance	RIGHT / LEFT / BOTH	
Are you currently employed?	Y / N	
Employer		
Work related injury?	Y / N	
Auto related injury?	Y / N	
If injured, is litigation ongoing?		

PATIENT NAME:_____

MED REC #: _____

ALL FLORIDA ORTHOPAEDIC ASSOCIATES

PAIN MANAGEMENT GUIDELINES:

Your physician at All Florida Orthopaedics takes pain management and the writing and use of prescriptions medications very seriously. The following guidelines will help guide you through your injury/illness from a pain management standpoint.

1. Prescriptions for pain medications have been written by your physician after great thought and consideration regarding your current diagnosis and plan of treatment. We are dedicated to providing for adequate pain management while following the guidelines set forth by federal regulators and the DEA.

2. It is **YOUR RESPONSIBILITY** to keep written prescriptions and all pain medications (especially narcotics) in a **SAFE AND SECURE** place. **Therefore, lost or stolen prescriptions and pain medications will not be refilled until your next scheduled office visit**.

3. It is our obligation to be aware of all pain medications that our patients have been prescribed and as a result of this obligation, we may periodically discuss your prescription refill history with your Primary Care physician and/or your pharmacist, for patient safety reasons. **Patients found to be receiving narcotic pain medications from multiple sources concurrently will be referred back to their Primary Care physician for future pain management needs.**

4. Should you be prescribed pain medications that are not serving your pain relief needs, we will make every attempt to prescribe different medications to meet these needs. However, All Florida Orthopaedics reserves the right to ask patients requesting different prescription medications to bring in their unused pills for disposal by an All Florida Orthopaedic staff member in order to avoid patients having multiple prescription medications on hand at a single time.

5. Pain management needs should be discussed with your physician at the time of your office visit. **Requests for prescription refills will only be done through our dedicated Medication Line (phone: 369-5059) during business hours only, Monday thru Friday**. No prescription refills will be called in after normal business hours, on weekends or holidays. Please note that there is a 48 hour turn-around time for medication refills, this includes patients presenting to the clinic in person for medication refill requests.

I have read the above guidelines. My signature indicates that I understand these guidelines and will abide by these guidelines as long as I am a patient of All Florida Orthopaedics.

_____	_____	_____
PATIENT	DATE	WITNESS

ALL FLORIDA ORTHOPAEDIC ASSOCIATES

_____An Orthopaedic Center of Excellence_____

Our office uses electronic messaging to communicate information regarding appointments and billing information. These electronic communications are done via automated calls, emails, and messaging through our patient portal.

Please sign below consenting to these electronic communications.

Please Print Name_____

Signature_____

Date_____