

OFFICE USE ONLY >>	PATIENT NUMBER	TYPE OF EXAM	DOCTOR NAME	INSURANCE NAME	<input type="checkbox"/> SMOKER
					<input type="checkbox"/> NON-SMOKER

FLORIDA CENTER FOR ORTHOPAEDICS PATIENT INFORMATION

PATIENT INFORMATION - PLEASE PRINT	REFERRED BY	TODAY'S DATE
---	-------------	--------------

LAST NAME	FIRST NAME	M.I.	HOME PHONE	WORK PHONE
STREET ADDRESS		AGE	D.O.B.	SOCIAL SECURITY#
CITY	STATE	ZIP	SEX	MARITAL STATUS
EMPLOYER NAME	ADDRESS		OCCUPATION	

////////////////////////////////////// SPOUSE/RESPONSIBLE PARTY //

LAST NAME	FIRST NAME	M.I.	HOME PHONE	WORK PHONE
STREET ADDRESS		D.O.B.	SOCIAL SECURITY#	
CITY	STATE	ZIP	SEX <input type="checkbox"/> M <input type="checkbox"/> F	
EMPLOYER NAME	ADDRESS		OCCUPATION	

////////////////////////////////////// EMERGENCY INFORMATION //

NAME - NOT LIVING WITH YOU	RELATIONSHIP	HOME PHONE	WORK PHONE
----------------------------	--------------	------------	------------

////////////////////////////////////// INSURANCE INFORMATION //

PRIMARY INSURANCE		SECONDARY INSURANCE	
INSURANCE COMPANY	PHONE	INSURANCE COMPANY	PHONE
ADDRESS		ADDRESS	
CITY/STATE/ZIP		CITY/STATE/ZIP	
I.D. NUMBER		I.D. NUMBER	
GROUP NAME OR NUMBER		GROUP NAME OR NUMBER	
POLICY HOLDER'S LAST NAME, FIRST NAME		POLICY HOLDER'S LAST NAME, FIRST NAME	
POLICY HOLDER'S SOCIAL SECURITY#	D.O.B.	POLICY HOLDER'S SOCIAL SECURITY#	D.O.B.
RELATIONSHIP TO GUARANTOR <input type="checkbox"/> SELF <input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE <input type="checkbox"/> PARENT <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	EMPLOYER INS. PLAN <input type="checkbox"/> YES <input type="checkbox"/> NO	RELATIONSHIP TO GUARANTOR <input type="checkbox"/> SELF <input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE <input type="checkbox"/> PARENT <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	EMPLOYER INS. PLAN <input type="checkbox"/> YES <input type="checkbox"/> NO

////////////////////////////////////// ASSIGNMENT OF BENEFITS - RELEASE OF INFORMATION //

I hereby assign all insurance benefits to which I am entitled, including Medicare, Medicaid, private insurance, major medical benefits and any other health plans to FLORIDA CENTER FOR ORTHOPAEDICS. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including HIV, substance abuse or psychiatric information which may be found in the record and is necessary to secure payment. There will be a \$25.00 charge for any returned check.

Patient or Responsible Party _____ Date _____

How did you hear about us? Yellow Pages Insurance Co. Referring Physician Friend Attorney

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

PLEASE SEE FRONT DESK IF YOU WOULD LIKE A COPY OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of Florida Center for Orthopaedics (FCO) Notice of Privacy Practices.

Signature of Patient or Legal
Representative

Date

If signed by Representative,
relationship to patient

OFFICE USE ONLY

Our organization has made a good faith effort to obtain a written Acknowledgement of Receipt of the Notice provided to the individual named below.

Patient Name: _____

Ch# _____

Refused to sign

Physically unable to sign

FCO Employee
Initials _____

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR
TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.**

NAME

BIRTHDATE

SOCIAL SECURITY#

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms,

examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restriction requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I REQUEST THE FOLLOWING RESTRICTIONS TO THE USE OR DISCLOSURE OF MY HEALTH INFORMATION :

PATIENT :

Signature of Patient or
Legal Representative

Date

Witness Signature

Today's Date: _____

FLORIDA CENTER FOR ORTHOPAEDICS, INC. MEDICAL HISTORY

Name: _____

D.O.B.: _____

Reason for Today's Visit: _____

Date of Injury: _____

Past Medical History

	YES	NO
Heart		
Lung		
Stomach		
Liver		
Kidney		
Anemia		

	YES	NO
Diabetes		
Mental Illness		
Cancer		
Thyroid		
Infectious Disease		
Other		

Please explain all "yes" answers: _____

Surgical History - List all procedures with Date, Place and Donor _____

Medications

_____	_____
_____	_____
_____	_____

Allergies to Medicine

_____	_____
_____	_____

Family History

	YES	NO
Heart		
Blood Pressure		
Diabetes		
Cancer		
Other		

Social History

Most Recent Occupation _____

Smoking History: None Previously Smoked Chews # _____ packs per day

Alcohol History: None Previously Occasional Moderate to Heavy Social

Marital Status: # _____ of Children

Name:

D.O.B.

REVIEW OF SYSTEMS

Have you complained of any of the following in the last six(6) months?

GENERAL

- Change in appetite
- Change in weight
- Chills, fever, sweats

YES	NO

HEAD

- Frequent headaches
- Recent trauma

EYES

- Reading glasses
- Blurred vision
- Double vision
- Contact lenses

EAR/NOSE/THROAT

- Loss of hearing
- Ringing in ears
- Nose bleeds
- Hoarseness
- Difficulty swallowing

RESPIRATORY

- Difficulty breathing
- Cough
- Shortness of breath
- Coughing up blood

HEART

- Chest pain
- Heart beating fast
- Murmur
- Mitral Valve Prolapse

DIGESTIVE SYSTEM

- Abdominal pain
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Blood in stool

URINARY SYSTEM

MALES ONLY

- Penile discharge
- Difficulty urinating
- Blood in urine
- Prostate trouble
- Frequent urination

URINARY SYSTEM

FEMALES ONLY

- Regular periods
- Vaginal discharge
- Difficulty urinating
- Blood in urine
- Frequent urination

YES	NO

MUSCLES/BONES

- Weakness
- Joint swelling
- Backache
- Neck ache
- Fractures
- Osteoporosis
- Knee pain
- Shoulder pain
- Ankle pain
- Other pain

NERVOUS SYSTEM

- Dizziness
- Loss of consciousness
- Seizures
- Burning sensation

SKIN

- Normal
- Rash
- Non-healing lesion

EMOTIONAL STATUS

- Nervousness
- Depression
- Insomnia

BLOOD/LYMPH SYSTEM

- Anemia
- Swollen glands
- Bleeding disorder
- History of clots

Incident Report

Dear Member,

Your insurance contract provides for benefits to be coordinated with other medical insurance by which you may be covered. The primary carrier pays first when there is more than one insurance company or health care provider. In order to expedite your claim(s) process, please complete the following information:

NOTE: If the reason for your medical care was not due to an accident related injury, do not complete Section 1 of the questionnaire. You should complete Section I and III only when applicable.

Patient Member ID Number _____

Patient Name _____

Provider Name _____

Date of Service _____

SECTION I

Is the reason for your visit to your doctor due to an injury caused by an accident?

Yes _____ No _____

If so, please indicate:

Auto _____ Home _____ School _____ Other _____

Date of Accident _____ How and where accident happened: _____

Was a third party responsible for the injury? Yes _____ No _____

If so, provide the following:

Name of individual or company: _____

Name and address of attorney representing third party insurance company or party responsible: _____

SECTION II

Full name of your spouse: _____

Spouse's Birth date: _____ Social Security Number: _____

Spouse's Employer: _____

Employer's Address: _____

Telephone Number: _____

Is your spouse covered by any other Health Insurance Company: _____ Yes _____ No

If YES, give name, address and telephone number of Health Insurance Company: _____

Telephone Number: _____

Policy Number: _____ Effective Date: _____

Type of Coverage: _____ Family _____ Couple _____ Single

Do you have Medicare coverage?

Part A _____ Effective Date _____ Part B _____ Effective Date _____

SECTION III (Information to be filled out only if auto accident)

Were you in your own or someone else's vehicle?

Name of your insurance company: _____

Amount of PIP coverage: _____ Amount of Deductible: _____

If represented by an attorney, please provide the following: Attorney name, address and telephone #:

Subscriber/Member Signature _____ Date

FLORIDA CENTER FOR ORTHOPAEDICS

PATIENT CONSENT AND AGREEMENT FOR "OFF-LABEL" PAIN TREATMENT

Reason for this Consent and Agreement

All prescription drugs in the United States have a label approved by the United States Food and Drug Administration. This label provides an indication and dosage for the drug, but neither physician nor patient is legally bound to follow them. Pain treatment is virtually impossible unless the physician prescribes one or more medications that are for an indication or dosage not listed on the drug label.

Consent and Agreement

The undersigned acknowledges that pain control cannot be achieved without "off-label" use of one or more drugs. The undersigned furthermore accepts all risks and complications that may occur from off-label use, since the benefit of pain control cannot otherwise be achieved. The undersigned agrees to waive all liability against the physicians and clinic who provide pain treatment.

Specific Off-Label Uses

Any and all off-label use of drugs are covered by this consent including, but not limited to the following:

1. The use of antidepressants, anti-epileptics, muscle relaxants, tranquilizers, and nutraceuticals for pain relief;
2. The administration of sustained release preparations of morphine and oxycodone used more frequently than every 12 hours;
3. Maximal dosage of opioids is to be determined by therapeutic effect rather than any arbitrary, published maximal dosing level;
4. Topical use of morphine, methadone, naloxone, carisoprodol, and ketamine.

I, the undersigned, agree to the above and release the physician and clinic of all liability for off-label use of drugs.

.....
Patient Signature

.....
Today's Date