ORTHOPAEDIC ASSOCIATES OF OSCEOLA
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To Our New Patient,

We would like to take this opportunity to welcome you to our practice, and thank you for choosing Orthopaedic Associates of Osceola.

Please complete the enclosed paperwork before coming to your appointment. This will allow you the time to think about each question and answer it thoroughly. Also be aware that we will need you to complete all paperwork annually. As you complete these forms, you may think of questions that you would like to ask your physician. Write down these questions and bring them with you to your appointment. **Please arrive to your first appointment at least 15 minutes before your scheduled appointment time so that we have time to process your new patient paperwork, and have your photo ID and insurance cards available so that they can be scanned.**

You **must** bring any xrays, CT scan, MRI (the actual films or cd), and any medical records that pertain to the reason you are seeing the physician to your appointment. **If you do not bring these at the time of your visit you will have to reschedule your appointment.**

If you have an HMO insurance plan, please bring the appropriate referral from your primary care physician. A written script from your primary care physician that says "Refer to Ortho" may not be an appropriate referral, verify with your insurance company. We are required by your insurance company to have this referral for your records. **If we do not have the appropriate referral for your visit you will have to reschedule your appointment until we have the referral needed for us to bill your insurance company.**

If you would like a copy of your office note sent to another physician, please provide their name, address, and phone/fax number.

Please remember to list all medications you are taking whether they are prescribed or over the counter and provide your preferred pharmacy address and phone number.

If this appointment is for a minor, a parent or legal guardian must be present for the initial visit. All other visits must have a signed consent from the parent or legal guardian.

Thank you again for allowing us to participate in your care. We look forward to meeting you.

ORTHOPAEDIC ASSOCIATES OF OSCEOLA PATIENT INFORMATION

Patient Last Name: ______________________ First Name: ______________________ MI: ____

Gender: ________ Date of Birth: ______________ SS #: ______________ Marital Status: ____

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ Type Unknown ☐ White

Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic ☐ Type Unknown

Primary Language: ______________________ Translation Needed? ☐ Y ☐ No

Mailing Address: ______________________ City: ______________ State: ____ Zip: ________

Alternate Address: ______________________ City: ______________ State: ____ Zip: ________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Email Address: ____ ☐ No Email

Employer/School: ______________________ Occupation: ______________________

Employer/School Address: ____

Name of Spouse: ______________________ DOB: ________ SS #: ______________

Spouse's Employer: ______________________ Phone: ______________

Emergency Contact Name: ______________________ Phone: ______________

How id you hear about us? ____

IF THE PATIENT IS A CHILD/FULL TIME STUDENT COMPLETE THIS SECTION

Name of **RESPONSIBLE** party for this patient's bill: ______________________

Mailing Address: ______________________ City: ______________ State: ____ Zip: ________

Mother's Name: ______________________ DOB: ________ SS #: ______________

Mother's Employer: ______________________ Phone: ______________

Father's Name: ______________________ DOB: ________ SS #: ______________

Father's Employer: ______________________ Phone: ______________

ACCIDENT QUESTIONNAIRE

☐ NO Accident ☐ AUTO Accident ☐ WORK Accident ☐ OTHER Accident

Date of Injury: ______________ Where did injury occur? ______________________

How did the injury/accident occur? ____

____

Primary Insurance: ______________________ **ID #:** ______________ **Grp. #:** ________

Insured DOB: ______________ Insured SS #: ______________________

Secondary Insurance: ______________________ **ID #:** ______________ **Grp. #:** ________

Insured DOB: ______________ Insured SS #: ______________________

ORTHOPAEDIC ASSOCIATES OF OSCEOLA HISTORY OF PRESENT COMPLAINT

Name: ______________________ Age: ________ Date: ____________

What body part is involved? (please check all that apply)

ANKLE:	☐ **R** ☐ **L**	**FOOT:**	☐ **R** ☐ **L**	**NECK:**	☐	**OTHER** ________	
ARM:	☐ **R** ☐ **L**	**HAND:**	☐ **R** ☐ **L**	**PELVIS:**	☐		
BACK:	☐	**HIP:**	☐ **R** ☐ **L**	**SHOULDER:**	☐ **R** ☐ **L**		
ELBOW:	☐ **R** ☐ **L**	**KNEE:**	☐ **R** ☐ **L**	**TOE:** ______	☐ **R** ☐ **L**		
FINGER: ______	☐ **R** ☐ **L**	**LEG:**	☐ **R** ☐ **L**	**WRIST:**	☐ **R** ☐ **L**		

On a scale of 0-10 (10 being the worst), how severe is your pain? ________ Duration of pain? ____________
What is the quality of your pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Other ________
What makes your symptoms worse? ☐ Bending ☐ Lifting ☐ Sitting ☐ Standing ☐ Walking ☐ Other ________
How often does the pain occur? ☐ Constant ☐ Intermittent ☐ Recurring ☐ Other ____________
Have you ever injured this area before? ☐ Y ☐ N Does your pain keep you awake at night? ☐ Y ☐ N
Have you missed any work because of this condition? ☐ Y ☐ N If so, how much? ____________

Date symptoms/injury occurred: ____________ Are symptoms/injury result of an accident? ☐ Y ☐ N

If yes, type of accident? ☐ AUTO ☐ WORKERS' COMP ☐ OTHER ____________

Description of the accident/injury: ______________________

____

Were you seen in the emergency room for this problem? ☐ Y ☐ N If so, which ER ____________

Have you had any diagnostic studies (xrays, MRI, etc.) done for this problem? ☐ Y ☐ N If yes, please indicate where and when: ______________________ Do you have them with you? ☐ Y ☐ N

Family/Primary Care Doctor: ____________ Referring Doctor: ____________

Preferred Pharmacy: ____________ Phone: ____________

HOME HEALTH/SKILLED NURSING FACILITY QUESTIONNAIRE

If you are currently receiving Home Health or residing in a skilled nursing facility (nursing home or rehabilitation facility), that entity may be responsible to pay for the services you receive today. It's important that we have the correct information on file.

Are you currently receiving Home Health? ☐ Y ☐ N If yes, which agency: ____________

Are you currently residing in a skilled nursing facility? ☐ Y ☐ No If yes, which facility: ____________

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient Signature: ______________________ Date: ____________

HEALTH HISTORY
(Confidential)

The following information is very important to your health and will better allow our practice to serve you.
Please take your time to fill out form completely.

Name: ______________________ DOB: __________ Age: ______
Height: ______________ Weight: ______________ Gender: ❑ Male ❑ Female

ALLERGIES
Are you allergic to any medicines (including any tape, iodine or latex)
❑ No ❑ Yes (If yes, please complete the allergy information below)

Medication Allergic to	Type of Reaction you experience

PAST SURGICAL HISTORY

Type of Operation	Date of Operation

CURRENT MEDICATIONS

Medication	Dose	Frequency		Medication	Dose	Frequency

SOCIAL HISTORY	Yes	No	
Do you smoke?	❑	❑	If yes, how much per day and how many years? ______
Have you ever smoked?	❑	❑	If yes, start date/quit date? ______
Do you drink alcohol?	❑	❑	If yes, how much and how often? ______
Do you do street/unprescribed drugs?	❑	❑	If yes, please specify. ______

Date of your last Tetanus Shot? ______________

MEDICAL HISTORY (Please check only if a history exists for yourself or a family member)

	Self	Family	Relationship to you		Self	Family	Relationship to you
Arthritis	❑	❑	______	Kidney Problems	❑	❑	______
Asthma	❑	❑	______	Liver Problems/Hepatitis	❑	❑	______
Blood Disorder	❑	❑	______	Lung Problems	❑	❑	______
Cancer	❑	❑	______	Neuro: Seizures, Epilepsy	❑	❑	______
Diabetes	❑	❑	______	Psychiatric	❑	❑	______
Gastrointestinal	❑	❑	______	STD	❑	❑	______
Genitourinary/Prostate	❑	❑	______	Skin Disorders	❑	❑	______
Heart Problems	❑	❑	______	Thyroid	❑	❑	______
High Blood Pressure	❑	❑	______	Other	❑	❑	______
High Cholesterol	❑	❑	______				

Women	Yes	No	Last Menses:
Pregnant	❑	❑	______
Hysterectomy	❑	❑	

Patient/Guardian Signature ______________________ Today's Date ______________

(The information provided on this form is true and correct to the best of my belief)

ORTHOPAEDIC ASSOCIATES OF OSCEOLA CONSENTS/AUTHORIZATIONS

Consent for Treatment & Medical Release Authorization: I hereby consent to treatment for myself, my child, or for whom I am the legally authorized representative. I authorize Orthopaedic Associates of Osceola (OAO) to release my protected health information (PHI) to any referring physician, other health care providers, hospitals and medical facilities, to my insurance carriers for the purpose of treatment, payment, and health care operation. I understand that this PHI may include reference to psychiatric care, alcohol and/or drug abuse, and results of tests for all infectious diseases including AIDS/HIV. I furthermore authorize OAO and staff to discuss my PHI in the presence of the family and visitors that accompany me during my visits.

Signature of Patient or Authorized Representative: ______________________ Date: __________

Financial Policy & Assignment of Insurance Benefits: Payment for medical services is the responsibility of the patient or the authorized representative. Our office will file for insurance benefits for plans in which we **participate**. For any insurance plans that we do not participate with and are considered **non-participating/out-of-network providers**, services rendered will not be billed to the insurance. It is your responsibility to ensure that you provide us with your correct insurance information and any referrals for care that are required. Payment for deductible, co-insurance, and co-payment amounts will be collected from the patient at the time of service. I hereby assign and authorize payment to Orthopaedic Associates of Osceola (OAO) of all medical and surgical benefits to which I am entitled, including health insurance benefits, major medical benefits, personal injury protection (PIP) benefits, and other medical payment coverage for which I am entitled. Please understand that your insurance policy is basically a contract between you and your insurance company. This assignment will remain in effect until revoked by me in writing. I authorize OAO to release all information necessary to secure payment of insurance benefits. **I understand that I am financially responsible for all charges whether or not paid by said insurance(s)**. For your convenience, we accept Visa, Master Card and Discover.

Signature of Patient or Authorized Representative: ______________________ Date: __________

Acknowledgement of Receipt of Privacy Rights: By signing below I acknowledge that I have read and had the opportunity to ask questions concerning Orthopaedic Associates of Osceola (OAO)'s Notice of Privacy Practices. This is to acknowledge that you have authorized us to:

**Contact me by any telephone numbers, email addresses, or other contact points provided by me, by the use of any automatic dialing system, pre-recorded forms of voice/messaging systems, email, telephone, cell phone, or text messages for reasons related to the services or payment for services I received at OAO.

**Please name the individuals with whom we can discuss all aspects of your protected health information (PHI):

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

☐ I **do not** authorize any information to be released to anyone other than myself.

**I hereby authorize messages to be left on a voice mail system or answering machine. Please indicate the number(s) OAO staff can utilize to leave a message for you:

______________________ ______________________ ______________________

**I have the right to revoke this consent in writing at any time except to the extent that OAO has already made disclosures in reliance upon my prior consent.

Signature of Patient or Authorized Representative: ______________________ Date: __________

Orthopaedic Associates of Osceola

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NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review carefully.

At Orthopaedic Associates of Osceola, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose health information to those involved in your treatment. For example, a review of your file by a specialist or referring doctor whom we may involve in your care. We may use or disclose health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose health information as part of our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answer machine or with the person who answers the phone.
In an emergency, we may disclose health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.
If this practice is sold, your information will become the property of the new owner. Except as described above, this practice we'll not use or disclose your health information without your prior written authorization.

You may request in writing that we do not use or disclosure your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the normal above uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but we'll be happy to include your statements in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Ave., S.W., Room 509F,Washington,DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our privacy officer, Stacey Crawley at 321-402-5043. This notice goes into effect as of April 14, 2003.