ADVANCED ORTHOPEDICS & SPORTS MEDICINE OF SWFL

PATIENT INFORMATION *Please print clearly*			
PATIENT'S NAME *(First, Middle Initial, Last)*:		□ Mr. □ Ms. □ Miss	□ Mrs. □ Dr.
DATE OF BIRTH:	**AGE:**	**SEX:** □ MALE □ FEMALE	
EMAIL ADDRESS:	**SOCIAL SECURITY #:**	**MARITAL STATUS:** □ SINGLE	□ MAR □ WID □ DIV
PERMANENT ADDRESS *(Street, City, State, Zip)*:			
FOR PART-TIME RESIDENTS **WINTER ADDRESS** *(Street, City, State, Zip)*: **OUT-OF-AREA PHONE#:**			
PREFERRED PHONE #:		□ CELL □ HOME □ OTHER	
ALTERNATE PHONE #:		□ CELL □ HOME □ OTHER	
WORK PHONE#:		**EMPLOYER:**	
EMPLOYER'S ADDRESS:			
IF STUDENT, SCHOOL NAME:			
PRIMARY CARE PHYSICIAN:			
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?	□ PRIMARY CARE PHYSICIAN □ HOSPITAL: □ OTHER PHYSICIAN: □ FRIEND OR RELATIVE: □ OTHER:	*Please provide us with your pharmacy information.* **PHARMACY:**_____ **PHONE:**_____ **LOCATION:**_____	
PLEASE DESCRIBE WHY YOU ARE HERE:		**DATE OF INJURY** *(if applicable)*:	

GUARANTOR		
Please complete this section: (1) If the patient is a minor by providing parent or guardian information or (2) your spouse, or other individual, is the insured party on your insurance policy.		
GUARANTEER'S NAME *(First, Middle Initial, Last)*:		**RELATIONSHIP TO PATIENT:** □ SPOUSE □ PARENT/GUARDIAN □ OTHER
DATE OF BIRTH:	**SOCIAL SECURITY #:**	
ADDRESS:	**CONTACT PHONE #:**	
EMPLOYER:	**EMPLOYER PHONE #:**	
EMPLOYER ADDRESS *(Street, City, State, Zip)*:		

ADVANCED ORTHOPEDICS & SPORTS MEDICINE OF SWFL

FINANCIAL RESPONSIBILITY & PAYMENT POLICY

We are committed to providing you with the best possible orthopedic care. If you have medical insurance, we would like to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, understanding and consent of our payment policy.

Your insurance is a contract between you and your insurance company. To understand your benefits, we recommend that you call the customer service number on the back of your insurance card or read the explanation of benefits (EOB) provided by your insurance carrier. Make sure you understand what your personal financial responsibilities and pre-authorization requirements are. Our staff will file claims with your health insurance carrier for reimbursement and payment will be made directly to Advanced Orthopedics & Sports Medicine of SWFL from your insurance company. However, deductibles, co-pays, co-insurance, and non-covered treatments are due at the time services are rendered. Any charges for returned checks will be passed along to you. If this account is referred to an attorney or collection agency, you are responsible for paying attorney's fees, collection expenses, court costs and recording fees. We accept cash, personal checks, and all major credit cards.

Depending on your insurance policy, certain medical services may require pre-authorization. It is your responsibility to obtain the appropriate authorization either from your primary care physician or from your insurance carrier. The staff at Advanced Orthopedics & Sports Medicine will assist you with the process. If services are not authorized in advance, you are responsible for the payment of those services. Furthermore, it is your responsibility to notify the staff at Advanced Orthopedics & Sports Medicine if your insurance changes during the course of your treatment.

CANCELLATION & NO-SHOW POLICY

We strive to meet and exceed the expectations of all our patients and to serve you on time. In order to do so, we ask all our patients to show cooperation by arriving at their scheduled time and to provide adequate notice when they need to reschedule. If you miss your appointment, without a 24-hour advance notice, you will be subject to a $25 no-show fee. This fee is not covered by insurance and must be paid before you are seen for your next appointment.

GENERAL CONSENT FOR TREATMENT

I do hereby voluntarily consent to medical treatment deemed as appropriate by the physician, physical therapist and any assistants for the above mentioned as necessary, in his/her professional judgement. I grant permission to voluntarily undergo any necessary tests, examinations, treatments, and other procedures required for the study, diagnosis and treatment by the medical and therapy staff of Advanced Orthopedics & Sports Medicine for my illness or injuries. I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of examination and/or treatments by the staff Advanced Orthopedics & Sports Medicine.

RELEASE OF MEDICAL RECORDS

I hereby authorize A Kagan & T Atkinson Orthopedics, its employees or agents, to release medical information regarding myself and my current condition to my insurance company for purpose of payment and/or quality reviews; and to referring, consulting, treating physicians, or other medical providers as needed to support continuity of care; all student athletes and their parents, by signature below, hereby grant consent for Advanced Orthopedics & Sports Medicine to release information and communicate with consulting athletic trainers or coaches.

I understand that original x-rays are the property of Advanced Orthopedics & Sports Medicine. Copies of my x-ray films will be provided to me, should I request them, but I am responsible to pay $10 per film when the copies are released.

I HAVE READ THIS CONSENT AND CERTIFY THAT I UNDERSTAND ITS CONTENTS. THIS AUTHORIZATION WILL REMAIN VALID UNLESS REVOKED IN WRITING.

Signature of PATIENT or PARENT/GUARDIAN

Date

SWFL ADVANCED ORTHOPEDICS & SPORTS MEDICINE

MEDICAL HISTORY FORM

PATIENT NAME: _____ DATE: _____

LOCAL PRIMARY CARE PHYSICIAN: _____

OUT OF STATE PRIMARY CARE PHYSICIAN: _____

REVIEW OF SYSTEMS					
GENERAL: Have you had a recent fever of 101.5 or greater?	Yes	No	**MUSCULOSKELETAL**: Do you currently have severe back pain?	Yes	No
SKIN: Do you have any rashes?	Yes	No	Do you have muscle weakness throughout your entire body?	Yes	No
NECK: Do you currently have any neck swelling?	Yes	No	**NEUROLOGICAL**: Do you frequently lose consciousness?	Yes	No
RESPIRATORY: Do you currently have any shortness of breath?	Yes	No	**ENDOCRINE**: Do you have fruity breath?	Yes	No
CARDIOVASCULAR: Do you currently have chest pain?	Yes	No	**HEMATOLOGY**: Have you ever had a deep vein thrombosis or pulmonary embolism?	Yes	No
GASTROINTESTINAL: Have you recently vomited blood?	Yes	No			

PAST MEDICAL HISTORY *Please circle each one applicable to your personal medical history.*		
Heart Attack Stroke High Blood Pressure Deep Venus Thrombosis (DVT) Pulmonary Embolism (PE) Cardiac Disease Angina Atrial Fibrillation	High Cholesterol Chronic Obstructive Pulmonary Disease Emphysema or Chronic Bronchitis Pulmonary Disease Abdominal Aortic Aneurysm Liver Disease Cancer: Type _____	Bleeding Difficulties Anemia Dizziness Diabetes Reflux Disease Peptic Ulcer Disease Gout Depression or Anxiety Disorder
ANY OTHER PAST MEDICAL HISTORY NOT LISTED?		

SURGICAL HISTORY

Please list all surgeries

MEDICATIONS

ALLERGIES

FAMILY HISTORY

Please list relevant health information below in reference to your natural parents or relatives.

Mother's medical history: _____

_____

Father's medical history: _____

_____

SOCIAL HISTORY

What do you do for recreation? _____

_____

Do you smoke cigarettes? Yes No

How many packs per day? _____

Do you drink alcohol? Yes No

How much per week? _____

Is there anything else we should know about you?