



**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
Guardian/Emergency Contact Name (Name, Address and Phone Number)			E-mail Address	
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, Arnold M. Ramirez 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. _____

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?

<input type="checkbox"/> Obesity <input type="checkbox"/> Cataracts <input type="checkbox"/> Chronic Sinus/Rhinitis <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Convulsions <input type="checkbox"/> Stroke <input type="checkbox"/> Depression <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Insomnia <input type="checkbox"/> Heart Trouble <input type="checkbox"/> Chest Pain/Angina <input type="checkbox"/> Heart Palpitation <input type="checkbox"/> Valvular Disease <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Hypertension	<input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> COPD <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Myocardial Infarction <input type="checkbox"/> DVT <input type="checkbox"/> Asthma <input type="checkbox"/> GERD <input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Stomach Ulcer <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Gallbladder Disease <input type="checkbox"/> Gout <input type="checkbox"/> Dialysis	<input type="checkbox"/> Back Pain <input type="checkbox"/> Spinal Stenosis <input type="checkbox"/> Scoliosis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Lupus <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Psoriasis <input type="checkbox"/> Bleeding/Bruising <input type="checkbox"/> Anemia <input type="checkbox"/> Cancer _____ <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Acute Infections <input type="checkbox"/> Alcoholism <input type="checkbox"/> Drug Abuse
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Past Surgical History

Have you ever had any of the following surgeries?

Date	Date	Date	Date
<input type="checkbox"/> ACL Surgery __/__/__	<input type="checkbox"/> CABG __/__/__	<input type="checkbox"/> Hernia Repair __/__/__	<input type="checkbox"/> Tonsillectomy __/__/__
<input type="checkbox"/> Angioplasty __/__/__	<input type="checkbox"/> Carpal Tunnel Release __/__/__	<input type="checkbox"/> Hip Replacement __/__/__	<input type="checkbox"/> Valve Replacement __/__/__
<input type="checkbox"/> Angio w/ Stent __/__/__	<input type="checkbox"/> Cataract Extraction __/__/__	<input type="checkbox"/> Knee Replacement __/__/__	Gender Specific
<input type="checkbox"/> Appendectomy __/__/__	<input type="checkbox"/> Cholecystectomy __/__/__	<input type="checkbox"/> Pacemaker __/__/__	<input type="checkbox"/> Cesarean Section __/__/__
<input type="checkbox"/> Arthroscopy __/__/__	<input type="checkbox"/> Gall Bladder Removal __/__/__	<input type="checkbox"/> Rotator Cuff Repair __/__/__	<input type="checkbox"/> Hysterectomy __/__/__
<input type="checkbox"/> _____ __/__/__	<input type="checkbox"/> Gastric Bypass __/__/__	<input type="checkbox"/> Thyroidectomy __/__/__	<input type="checkbox"/> Mastectomy __/__/__
<input type="checkbox"/> Back Surgery __/__/__			
<input type="checkbox"/> 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	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	Drug Abuse	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___
Alcoholism	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	Gout	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___
Alzheimer's Disease	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	Heart Disease	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___
Arthritis	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	Hypertension	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___
Blood Disease	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	Kidney Disease	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___
Cancer	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	Liver Disease	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___
COPD	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	Mental Illness	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___
CVA (Stroke)	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	Obesity	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___
Depression	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	Other	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___
Diabetes	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	_____	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___	<input type="checkbox"/> ___

Social History

Language

Primary Language Spoken	Primary Language Spoken at Home
Birthplace	Hand Dominance <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Ambidextrous

Education/Employment/Occupation/Military Experience

Name of School	Degree Obtained	Country
Employer		
Occupation		
Employment Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired (Date: _____) <input type="checkbox"/> Laid Off <input type="checkbox"/> Active Military Duty <input type="checkbox"/> Activated Military Reserve <input type="checkbox"/> Disabled <input type="checkbox"/> Private Disability <input type="checkbox"/> Social Security Disability <input type="checkbox"/> Child		
Restrictions <input type="checkbox"/> Avoid Dust/Fumes <input type="checkbox"/> No Climbing <input type="checkbox"/> No Heavy Lifting		

Marital Status/Family/Social Support

Marital Status: Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>

Tobacco

Use Tobacco? Y / N / Formerly
If Yes or Formerly: Type: <input type="checkbox"/> Chewing <input type="checkbox"/> Cigar <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Smokeless
Number of Years _____
Tobacco per Day: <input type="checkbox"/> Less than 1 pack/day <input type="checkbox"/> Greater than 1 pack/day <input type="checkbox"/> 1 pack/day <input type="checkbox"/> Less than 2 bowls/day <input type="checkbox"/> More than 2 bowls/day <input type="checkbox"/> 1 can/day <input type="checkbox"/> ½ can/day
Ever tried to quit? Y / N Year Quit _____

Alcohol

Drink Alcohol? Y / N / Formerly If Formerly, year quit _____
Frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Socially

Advanced Directives in Place

<input type="checkbox"/> None <input type="checkbox"/> Do Not Resuscitate <input type="checkbox"/> Living Will
<input type="checkbox"/> Durable Power of Attorney <input type="checkbox"/> Healthcare Proxy

