Patient Registration

Last Name: _____

First Name: _____

Preferred Name: _____

Middle Name, Suffix: _____

Former Last Name: _____

Sex: _____

DOB: _____

SSN: _____

Address: _____

Address ctd: _____

City: _____

State: _____ Zip: _____

Country: _____

Home Phone: _____

❑ Same as mobile phone

Mobile Phone: _____ ❑ None

Work Phone: _____

Patient Email: _____ ❑ No Email

(The patient will not have a portal access without an email)

Contact Preference: _____

Registration Department: _____

Language: _____ ❑ Patient Declined

Ethnicity: _____ ❑ Patient Declined

Marital Status: _____

Homebound? ❑ Yes ❑ No

Primary Care Physician: _____

Skilled Nursing Facility: _____

How did you hear about us? _____

OAWF
ORTHOPAEDIC ASSOCIATES OF WEST FLORIDA

Date: _____

Guardian

Last Name: _____

First Name: _____

Middle Name, Suffix: _____

Emergency Contact

Name: _____

Relationship _____

Home Phone: _____

Mobile Phone: _____

Next of Kin

Name: _____

Relationship _____

Phone: _____

If reason for your visit is Workers Comp.

Employer Name: _____

Employer Phone: _____

Usual occupation: _____

Current or most recent: _____

Usual Industry: _____

Guarantor Information

Patient's relationship to guarantor: _____

Guarantor (name to whom statement are sent)

Last Name: _____

First Name: _____

Middle Name, Suffix: _____

DOB: _____

Mailing Address ❑ Same as Patient's address

Address: _____

Address (ctd): _____

City: _____

State: _____ Zip: _____

Country: _____

Optional information

SSN _____

Phone: _____

Email: _____ ❑ No Guarantor Email

Employer: _____

OAWF
ORTHOPAEDIC ASSOCIATES OF WEST FLORIDA

FINANCIAL POLICY

Welcome to OAWF. Please read the following for your financial obligation. You understand and agree that you are responsible and liable for payment of all charges for professional services rendered. If our office is participating with your insurance and accepts assignment, this means that we will accept what your insurance allows for the services performed which is less than our standard billed amount. Based on your plan, our office will collect an **estimated** patient responsibility amount at the time of your visit. Once your claim processes through your insurance, the patient responsibility may be more or less than the original **estimated** amount. You will receive a statement in the mail if there is a balance due by you that is due upon receipt. If you have a credit, our office will apply that credit to any open patient balances on your account. It is our office policy to hold all credits on your account until all open claims have processed by your insurance company.

You authorize payment of medical benefits to the physician/care center performing the professional services. In the event your insurance company forwards payment directly to you, you will deliver such payment to the physician/care center where services were performed.

PRIVATE PAY: Full payment is expected when services are rendered. We accept checks, cash, and most major credit/debit cards. *There is a charge for any returned checks*

PPO's & HMO's: You will be responsible for any copays, deductible, co-insurances, and non-covered services.
****It is the patient's responsibility to verify any required authorizations/referrals are in place prior to their visit****

Medicare: We are Medicare providers and accept Medicare assignment. You are responsible for the Medicare yearly deductible, co-insurance, and non-covered services. We will also file your secondary insurance as courtesy. If your secondary insurance does not make payment, you are responsible for this balance.

Medicaid: We do not participate with any Medicaid HMO's. The patient is responsible for payment if you have a Medicaid HMO.

Worker's Compensation: All authorized charges will be billed directly to the worker's compensation carrier. In the event your claim or service is denied, you will be responsible for this balance.

Auto/Personal Injury: For auto accidents or personal injury accidents it is your responsibility to provide us with your accident claim number and adjustors name and telephone number prior to your visit. On your initial visit for auto accidents, you must sign a DISCLOSURE AND ACKNOWLEDGMENT FORM for PIP benefits in order for us to be paid. You are responsible for any deductibles, copays, co-insurances, or non-covered services. We file auto insurance and accept assignment of benefits. We will also file your personal injury insurance, if applicable.

Litigation/Attorney: If our office agree to accept a Letter of Protection, you are required to contact your attorney to provide this to us prior to treatment. You are ultimately responsible for any charges held under a letter of protection when your case settles or the letter of protection becomes invalid. Some services may not be held under the letter of protection at the discretion of the physician's office.

Minors: In the case of minors, any required payment is expected at the time of service. Required payment is the responsibility of the person bringing the child in for treatment. In no case shall a parent be billed unless prior arrangements have been made directly with that parent.

By signing below you are stating you understand and agree to all of the above terms and polices:

"I understand that I am ultimately responsible for all charges incurred regardless of my existing medical coverage. I accept responsibility for all patient balances due according to the above terms. Should my account become past due, the full balance is due and payable immediately. I will be responsible for all collection and legal costs incurred for collecting the delinquent balance on my account."

_____ _____ _____

Patient/Guardian Signature Patient/Guardian Printed Name Date

WWW.OAWF.COM
(727) 461-6026

OAWF
ORTHOPAEDIC ASSOCIATES OF WEST FLORIDA

430 Morton Plant St., Suite 301 • Clearwater, FL 33756 • Fax 727-461-1492
8839 Bryan Dairy Rd., Suite 240 • Largo, FL 33777 • Fax 727-397-0562
3251 N McMullen Booth Rd., Suite 201• Clearwater, FL 33761 • Fax 727-796-4345
2044 Trinity Oaks Blvd., Suite 110 • Trinity, FL 34655 • Fax 727-372-0235

Patient Name: _____ Acct No. _____

TO WHOM MAY WE DISCLOSE YOUR HEALTH INFORMATION

In accordance with HIPAA (Health Insurance Portability and Accountability Act), and the related policies and procedures of Orthopaedic Associates of West Florida, each patient may designate those individuals to whom health professionals may discuss or share information relevant to your health care.

To whom may we release information on your behalf?_____

_____

_____

_____ _____

Signature Date

OAWF
ORTHOPAEDIC ASSOCIATES OF WEST FLORIDA

Account #	Patient:

Coordination of Benefits & HIPAA Acknowledgment

Dear Patient,

Your insurance contract(s) may provide for benefits to be coordinated with other medical insurance by which you may be covered. In this case, your primary insurance pays first when there is more than one insurance company. Please complete the portions below if applicable.

Section 1

Name of Physician/Provider you are seeing: _____

Is the reason for your visit due to an injury caused by an accident? ❑ Yes ❑ No

If Yes, please indicate the type of accident: ❑ Auto Accident ❑ Work ❑ School ❑ Home

❑ Other Please describe _____

Is a third party responsible for your injury? ❑ Yes ❑ No Who? _____

Section 2 (Please complete if injury is related to an auto accident)

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

Name of Auto Carrier? _____ Adjuster _____

Phone # _____ Claim # _____ Date of injury _____

Do you have an Attorney? ❑ Yes ❑ No If yes, who? _____

attorney Phone# _____ Legal aide/contact _____

Section 3 (Please complete if injury is related to a workers comp. claim)

Employer at the time of the injury _____

Date of injury _____ Work Comp Ins. Carrier _____

Adjuster _____ Phone# _____

Case Manager _____ Phone# _____

Do you have an Attorney? ❑ Yes ❑ No If yes, who? _____

Please read below and sign.

To the best of my knowledge, the statements above are true. Unanswered questions indicate they do not apply. My signature authorizes my insurance carrier to receive any payment and all information concerning claims filed by me or on my behalf to another insurance carrier for the purpose of coordination of benefits.

My signature also serves as acknowledgement that upon request I will be provided a copy of the HIPAA privacy policy.

_____ _____

Signature Date

ORTHOPAEDIC ASSOCIATES OF WEST FLORIDA

MEDICAL HISTORY FORM

Patient Name: _____ **Date of Birth:** _____
Height: _____ **Weight:** _____
Part of the body being seen for today: ○ R ○ L ○ Both _____
Referring Physician: _____ **Primary Care Physician:**_____

In this section, check the box which best describes how your problem started. Please answer the questions related to the box you checked.

○ **NO INJURY** Was the onset ○ Gradual ○ Sudden Onset Date: _____ ○ **INJURY** ○ Accident ○ Sport Date: _____ ○ **INJURY AT WORK** Date: _____ ○ Lift ○ Twist ○ Fall ○ Bend ○ Pull ○ Reach ○ Repetitive ○ **AUTO ACCIDENT** Date: _____	**Description of Visit / Injury** _____ _____ _____ _____ _____ _____

Have you had a problem like this before? ○ Y ○ N

Were you seen by another physician or in the E.R. for this problem? ○ Y ○ N Which Physician? _____
What test scans have you had for this problem?
○ X-rays ○ MRI ○ CAT Scan ○ Bone Scan ○ Nerve Test (EMG / NCV)
Please enter results: _____ _____
On a scale of 0-10 (10 is the worst) how severe is your pain? ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10
What is the quality of pain? ○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning

The pain is ○ Constant ○ Intermittent (comes & goes) Does the pain wake you from your sleep? ○ Y ○ N
I experience: ○ Swelling ○ Bruising ○ Numbness ○ Tingling ○ Weakness ○ Loss of control of bowel or bladder
○ Locking / Catching ○ Giving way ○ Pain ○ Stiffness Other _____

Since my problem started, it is: ○ Getting Better ○ Getting worse ○ Unchanged

What makes your symptoms worse: ○ Standing ○ Walking ○ Lifting ○ Twisting ○ Bending ○ Stairs ○ Exercise
○ Squatting ○ Kneeling ○ Sitting ○ Coughing ○ Sneezing ○ Lying in bed

What makes your symptoms better?: ○ Rest ○ Elevation ○ Ice ○ Heat Other:_____

PAST MEDICAL HISTORY

List all previous hospitalizations and surgeries: ○ **None**

○ Left ○ Right Total Knee Replacement	○ Tonsils Removed	○ Pacemaker	○ C-Section
○ Left ○ Right Total Hip Replacement	○ Gallbladder	○ Hysterectomy	○ Other Orthopedic Surgery
○ Left ○ Right Carpal Tunnel Surgery	○ Hernia	○ Tubal ligation	○ Other Heart Surgery
○ Cardiac Catherization ○ with Stent	○ Appendix Removed	○ Vasectomy	
Please list all other surgeries: _____			
Any of the above within the last 2 years? ○ Y ○ N			

Are you taking blood thinners? ○ Y ○ N If Yes, which one? _____

List any medications you are taking on a regular basis (including hormonal replacement therapy or birth control) along with why you are taking the medication:

○ None	Medication (Name and Strength)	Reason
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_ _____	_____

Patient Name: _____

PAST MEDICAL HISTORY

List any allergies to medications:	Reaction and side effects to allergies to medications:
_____	_____
_____	_____
_____	_____

Other Allergies? ○ Y ○ N If Yes, what are they? _____

Latex allergy? ○ Y ○ N **Iodine allergy?** ○ Y ○ N **Shellfish allergy?** ○ Y ○ N **Contrast allergy?** ○ Y ○ N

Do you have a personal history or any of the following? ○ **NONE**

○ Excessive or Prolonged Bleeding	○ Peripheral Vascular Disease	○ HIV / AIDS	○ Stroke
○ Blood Clots	○ Diabetes Type: _____		○ Sleep Apnea
○ Asthma	○ Reaction to Anesthesia Type: _____		○ Chemical Dependency
○ Stomach Ulcers	○ Cancer Type: _____		○ Chemotherapy
○ GERD	○ Arthritis Type: _____		○ Radiation
○ Problems with Wounds Healing	○ Hepatitis	○ High Blood Pressure	○ Depression
○ Emphysema	○ Bone or Joint Infections	○ Heart Attack	○ Anxiety
○ Birth Defects	○ Thyroid Disease	○ Coronary Artery Disease	○ Seizures
○ Lung Disease	○ Fractures / Joint Dislocations	○ Cardiac Arrhythmia	○ Tuberculosis
Are you Pregnant? ○ Y ○ N	○ Other Heart Disease: _____		

REVIEW OF SYSTEMS

HAVE YOU HAD ANY OF THESE CURRENTLY OR IN THE LAST 6 MONTHS?					**NONE**	**COMMENTS**
1) GI	○ Heartburn ○ Ulcers	○ Nausea ○ Vomiting	○ Blood in Stool		○	_____
2) ENDO	○ Cold or ○ Heat Intolerance	○ Excessive Urination	○ Excessive Hunger		○	_____
3) CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue		○	_____
4) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss		○	_____
5) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing		○	_____
6) CV	○ Chest Pain	○ Palpitations	○ Irregular Heartbeat		○	_____
7) RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath		○	_____
8) GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems		○	_____
9) SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps	○ Psoriasis	○	_____
10) NEU	○ Headaches	○ Dizziness	○ Seizures	○ Numbness	○	_____
11) PSY	○ Depression / Anxiety	○ Drug / Alcohol Addiction	○ Sleep Disorder		○	_____
12) HEM	○ Easy Bleeding	○ Easy Bruising	○ Anemia		○	_____

FAMILY HISTORY

HAVE ANY DIRECT RELATIVES HAD ANY OF THE FOLLOWING DISORDERS?						
FATHER:	○ None	○ Diabetes	○ Heart Disease	○ Cancer	○ Bleeding Problems	○ Rheumatoid Arthritis
MOTHER:	○ None	○ Diabetes	○ Heart Disease	○ Cancer	○ Bleeding Problems	○ Rheumatoid Arthritis
SIBLING:	○ None	○ Diabetes	○ Heart Disease	○ Cancer	○ Bleeding Problems	○ Rheumatoid Arthritis

SOCIAL HISTORY

Do you use tobacco? ○ Y ○ N If Yes, packs per day _____ ○ Quit **Informed of Smoking Risk?** ○ Y ○ N

Alcohol use? ○ Y ○ N ○ Quit I f Yes, how much _____

Marital History: ○ Married ○ Single ○ Divorced ○ Widowed

Are you currently working? ○ Y ○ N ○ Retired ○ Disabled If no, when did you last work? _____

Are you currently on any work restrictions? ○ Y ○ N If Yes, what are they? _____

Occupation: _____ **Employer:** _____

_____ _____

Signature **Date**

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

Definitions: Within this document, the term 'I' shall hereinafter be interpreted as the patient or guardian/representative empowered to consent to treatment on behalf of the patient. 'OAWF' shall hereinafter be interpreted as Orthopaedic Associates of West Florida.

Consent: This consent provides OAWF with my permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, I am indicating that (1) I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) I consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. I have the right at any time to discontinue services.

I have the right to discuss the treatment plan with my medical provider about the purpose, potential risks, and benefits of any test ordered for me. If I have any concerns regarding any test or treatment recommended by my health care provider, I am encouraged to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or their designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, or invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Patient Consent for E-Prescribing (Electronic Prescribing): I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been given information and understand that my providers using the electronic prescribing system will be able to see information about medications I take, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

Notice of Privacy Practices: Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I may receive a copy of OAWF's Notice of Privacy Practices upon request. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at OAWF, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

No Guarantee: I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care, or examination within the Practice.

Accuracy and Integrity: I hereby acknowledge the information I provided on the patient information form and patient history to be true and correct and completed to the best of my ability.

Advance Care Planning: Advance care planning involves learning about the types of decisions that might need to be made, considering those decisions ahead of time, and then letting others know—both your family and your healthcare providers—about your preferences. These preferences are often put into an *advance directive*, a legal document that goes into effect only if you are incapacitated and unable to speak for yourself.

□ I have an Advance Care Plan in place. _____ is my health care agent.

□ I do not wish to designate a person as a health care agent at this time.

□ I would like more information regarding Advance Care Planning.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	Date
Printed name of Patient or Personal Representative	Relationship to Patient
Signature of Witness	Employee Job Title
Printed Name of Witness	Date