ORTHOPEDIC SPECIALISTS OF SW FLORIDA
PATIENT REGISTRATION

PATIENT INFORMATION: (PLEASE USE FULL LEGAL NAME)			
Last Name:	First Name:		Middle Initial:
Date of Birth:	Sex:	Social Security #:	
Address:			
City:	State:	Zip:	
Home Phone #:	Cell Phone #:		
Email Address:			
Employer Name:	Occupation:		
Primary Care Physician (PCP):	PCP Phone #:		
Referring Physician:	Ref Phone #:		

INSURANCE INFORMATION			
PRIMARY MEDICAL INSURANCE			
Insurance Company:		☐ HMO ☐ PPO ☐ POS	
Policy Number:	Group Number:		
Policy Holder's Name:	Policy Holder's Date of Birth:		
Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Parent ☐ Other			
SECONDARY MEDICAL INSURANCE			
Insurance Company:		☐ HMO ☐ PPO ☐ POS	
Policy Number:	Group Number:		
Policy Holder's Name:	Policy Holder's Date of Birth:		
Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Parent ☐ Other			

GUARANTOR INFORMATION (PLEASE FILL OUT IF THE PATIENT IS UNDER 18)			
Last Name:	First Name:	Relationship to Patient:	
Date of Birth:	Phone #:	Social Security #:	
Address:	City:	State:	Zip:

PATIENT NAME:_____ACC #:_____DATE OF BIRTH:_____

OFFICE USE ONLY

ASSIGNMENT OF BENEFITS AND PATIENT RESPONSIBILITY

I authorize Orthopedic Specialists of Southwest Florida ("OSSWF") to release information from my medical record as needed to process insurance claims. I assign and authorize direct payment of insurance benefits, including Medicare, PIP, or other health benefits, to OSSWF. I understand that I am financially responsible for all charges not covered by my insurance, including deductibles, co-pays, co-insurance, and non-covered services. Payment is due at the time of service, and I remain responsible for the full balance of my account regardless of my insurance coverage. I authorize OSSWF to share medical records with other physicians or facilities involved in my care when necessary.

Patient Name: Date:

Signature:

AUHORIZATION OF RELEASE OF HEALTH INFORMATION

Our office will not communicate your PHI to any other entity not listed on this form. If you have adult children, extended family members, caretakers, or other persons whom you want us to be able to speak to on your behalf regarding treatment, clinical, and administrative functions in our office you will need to list the person(s) below.

☐ I hereby authorize Orthopedic Specialists of SW Florida and its employee's permission to discuss, send, and/or receive my personal health information to/with the following individual(s):

Name: Relationship: Phone:

Name: Relationship: Phone:

Name: Relationship: Phone:

☐ I do not wish any other entity or person other than myself to be able to discuss my care or treatment with this office.

Signature: Date:

PATIENT NAME:_____ACC #:_____DATE OF BIRTH:_____

OFFICE USE ONLY

ORTHOPEDIC SPECIALISTS OF SW FLORIDA
MEDICAL HISTORY FORM

PATIENT INFORMATION	
Patient Name:	Date of Birth:
Pharmacy:	Pharmacy Address:
Height: _____ft____in	Weight:_____lbs
Do you have a health care proxy in the event that you are unable to make your own medical decisions? ☐ Yes ☐ No	
Designee Name:	Phone Number:
Do you have a living will? ☐ Yes ☐ No	

CHIEF COMPLAINT	
Body Part:	Side: ☐ Right ☐ Left
Have you been seen in the ER for this problem? ☐ Yes ☐ No	
If yes, which Emergency Room? _____	If yes, please provide the date: _____

SOCIAL HISTORY	
Do you smoke tobacco? ☐ Yes ☐ No ☐ Former If yes, do you smoke ☐ Daily ☐ Occasionally	Do you smoke recreationally? ☐ Yes ☐ No ☐ Former
Do you drink alcohol? ☐ Yes ☐ No If yes, do you drink ☐ daily ☐ 2-3 times a week ☐ socially	
Are you currently working? ☐ Yes ☐ No	If yes, list any restrictions: If no, are you ☐ retired ☐ disabled ☐ student

MEDICAL HISTORY

Do you have a personal history of the following?

☐ None	☐ COPD	☐ Heart Attack	☐ Pulmonary Embolism
☐ Anesthesia Reaction	☐ Congestive Heart Failure	☐ Hepatitis Type: ____	☐ Seizures
☐ Arthritis	☐ Claustrophobia	☐ HIV / AIDS	☐ Stroke
☐ Blood Clots	☐ Diabetes	☐ High Blood Pressure	☐ Stomach Ulcers
☐ Bone / Joint Infections	☐ Drug / Alcohol Abuse	☐ High Cholesterol	☐ Other: _____
☐ Cancer	☐ Emphysema	☐ MRSA	☐ Other: _____

PATIENT NAME:_____ACC #:_____DATE OF BIRTH:_____

OFFICE USE ONLY

Have any direct relatives suffered from the conditions below? Please check the appropriate box.

Condition	*Father*	*Mother*	*Sibling*
None (No Medical Conditions)	☐	☐	☐
Unknown	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Osteoporosis	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Stroke	☐	☐	☐

PREVIOUS HOSPITALIZATIONS / SURGERIES

Surgery

- ☐ Aneurysm (Brain) Surgery
- ☐ Aortic Bypass / Vascular Surgery
- ☐ Appendectomy
- ☐ Cataract (Eye) Surgery
- ☐ Cholecystectomy (Gallbladder)
- ☐ C-Section
- ☐ Heart Surgery
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ LAP Band / Gastric Bypass Surgery
- ☐ Malignancy / Cancer
- ☐ Stents
- ☐ Tonsillectomy

PREVIOUS ORTHOPEDIC SURGERIES

Surgery	**Right**	**Left**
Arthroscopy: Knee	☐	☐
Arthroscopy: Shoulder	☐	☐
Carpal Tunnel	☐	☐
Total Shoulder	☐	☐
Total Knee	☐	☐
Total Hip	☐	☐
Rotator Cuff Repair	☐	☐
Spinal Surgery Neck (Indicate Levels)		
Spinal Surgery Back (Indicate Levels)		

Please list any other orthopedic (bone, muscle, joint) surgeries you have undergone:

Please list any other surgeries you have undergone:

PATIENT NAME:_____ACC #:_____DATE OF BIRTH:_____

OFFICE USE ONLY

REVIEW OF SYSTEMS OVER THE PAST 6 MONTHS. PLASE CHECK ANY THAT APPLY.					
GENERAL	☐ Weight Loss	☐ Loss of Appetite	☐ Fatigue	☐ Weakness	☐ None
EYE	☐ Blurred Vision	☐ Double Vision	☐ Vision Loss		☐ None
ENT	☐ Hearing Loss	☐ Hoarseness	☐ Trouble Swallowing	☐Ear Pain / Ringing	☐ None
	☐ Tooth / Gum Issues	☐ Nose Bleeds			
CARDIOVASCULAR	☐ Chest Pain	☐ Palpitations	☐ Heart Attack	☐ High Blood Pressure	☐ None
RESPIRATORY	☐ Chronic Cough	☐ Pulmonary Embolism	☐ Shortness of Breath	☐ Pneumonia	☐ None
GI	☐ Heartburn / Ulcers	☐ Nausea / Vomiting	☐ Blood in Stool	☐ Stomach Pain	☐ None
GENITOURINARY	☐ Painful Urination	☐ Blood in Urine	☐ Kidney Problems	☐ Irregular Periods	☐ None
SKIN	☐ Frequent Rashes	☐ Skin Ulcers	☐ Lumps	☐ Psoriasis	☐ None
NEUROLOGICAL	☐ Frequent Falls	☐ Loss of Coordination	☐ Numbness	☐ Change in Bowel	☐ None
	☐ Change in Bladder	☐ Dizziness	☐ Blackouts	☐ Frequent Headaches	
PSYCHOLOGICAL	☐ Depression / Anxiety	☐ Drug Addiction	☐ Alcohol Abuse	☐ Sleep Disorder	☐ None
ENDOCRINOLOGY	☐ Fever	☐ Heat / Cold Intolerance	☐ Night Sweats		☐ None
HEMATOLOGY	☐ Easy Bleeding	☐ Easy Bruising	☐ Anemia	☐ DVT	☐ None
MUSCULAR	☐ Osteoarthritis	☐ Muscular Weakness	☐ Muscular Pain		☐ None
MISCELLANOUS	☐ Joint Pain	☐ Joint / Limb Swelling	☐ Stiffness		☐ None

Please list or provide a list of all allergies to medication, food, and environmental factors: (☐ No Known Allergies)

Please list or provide a list of all current medications: (☐ No Current Medications)

Signature: Date:

PATIENT NAME:_____ACC #:_____DATE OF BIRTH:_____
OFFICE USE ONLY

ORTHOPEDIC SPECIALISTS OF SW FLORIDA
CONSENTS

CONSENT FOR TREATMENT

I consent to medical care and treatment by the physicians of Orthopedic Specialists of Southwest Florida and their healthcare team. This may include examinations, x-rays, blood tests, or other diagnostic procedures that my physician determines are necessary. If unexpected conditions are found during treatment, I authorize my doctor to address them as needed.

I understand that all medical treatments have potential risks and benefits, and that no outcome can be guaranteed. My doctor will explain my condition, proposed treatments, alternatives, and risks, including the risks of not receiving treatment. I may ask questions at any time, and I understand that I may stop treatment if I need clarification.

I agree to provide accurate and complete medical history, including medications I have taken. I understand that my medical care may involve review of past and current records, test results, and prescription history as needed.

I also understand that Florida law allows physicians to practice without medical malpractice insurance if certain conditions are met. The physicians of Orthopedic Specialists of Southwest Florida have elected not to carry malpractice insurance, as permitted by law.

By signing below, I confirm that I understand and agree to this consent and that I have been offered assistance or an interpreter if needed.

Patient Name: Date:

Signature:

FINANCIAL POLICY

I understand that I am responsible for payment of all deductibles, co-pays, co-insurance, and any services or supplies not covered by my insurance, including items such as braces, slings, and splints. Payment is due at the time of service.

As a courtesy, Orthopedic Specialists of Southwest Florida will submit claims to my insurance company. Any balance not paid by insurance remains my responsibility. Requests for form completion may incur a fee of up to $50. Returned checks are subject to a $35 fee.

If my account is not paid in full or arrangements for payment are not made, it may be sent to collections. I may be responsible for additional costs, including collection fees, attorney fees, court costs, interest, and other related expenses.

By signing below, I confirm that I understand and agree to this financial policy.

Patient Name: Date:

Signature:

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I may request a copy of our “Notice of Privacy Practices.” I further acknowledge that a copy of the current notice will be posted in the waiting area.

Patient Name: Date:

Signature:

PATIENT NAME:_____ACC #:_____DATE OF BIRTH:_____
OFFICE USE ONLY

ORTHOPEDIC SPECIALISTS OF SW FLORIDA
ACCIDENT / INJURY FORM

PATIENT INFORMATION	
Patient Name:	Date of Birth:
INJURY INFORMATION	
Reason for Today's Visit:	Was this an injury? ☐ Yes ☐ No
Date of Injury/Accident:	If yes, where did this injury occur? ☐ Work ☐ Auto ☐ Home ☐ School
Body Part:	Side: ☐ Right ☐ Left
How did this injury occur?	

If Auto / Motorcycle:

Name of Auto / Med Pay Insurance Carrier: | Claim #:

Has a claim been made with your auto insurance carrier? ☐ Yes ☐ No

Were you the ☐ driver or ☐ passenger? | Do you own the vehicle? ☐ Yes ☐ No

If *motorcycle* related, do you have Med Pay that would cover medical expenses relating to this accident? ☐ Yes ☐ No

If Work:

Name of employer at the time of injury:

Are you self-employed? ☐ Yes ☐ No | Do you receive? ☐ W-2 ☐ 1099

Have you filed a Workers' Compensation claim? ☐ Yes ☐ No

Has the employer or the Workers' Compensation carrier accepted or denied liability? ☐ Accepted ☐ Denied

If Other:

Please provide a description of how the accident occurred

ATTORNEY INFORMATION	
Have you sought the assistance of an attorney relating to this accident / injury? ☐ Yes ☐ No	
Attorney's Name	Attorney's Phone #:
Attorney's Address	

To the best of my knowledge the above information is true, accurate and complete. Unanswered questions indicate they do not apply. My signature authorizes any Medicare carrier, intermediary, insurance carrier, or plan to make available to my health insurance company _____ all records necessary for processing claims filed by me or on my behalf. I authorize all insurance payments, including auto, PIP, and Med Pay to be made directly to Orthopedic Specialists of SW Florida. I authorize my auto insurance carrier _____ to release information regarding my PIP benefits and to provide a PIP log to OSSWF when requested.

Signature: Date: