ORTHOPAEDIC ASSOCIATES OF ST. AUGUSTINE

Welcome to our office. We are committed to providing you with the most comprehensive care possible. Please assist us in doing so by providing the following information as well as your driver's license and insurance card(s).

Today's Date: ______________________

Last Name: ______________________ **First Name:** ______________________ **Middle:** __________

Address: ______________________________________ **Apt./Lot #:** ______________

City: ______________________ **State:** ______________ **Zip Code:** __________

Phone (H): (____) ______________ **(W):** (____) ______________ **(Cell):** (____) ______________

SS #: ________ - ______ - ____________ **Birth Date:** ________ / ________ / ________

Employer: ______________________________ **Position:** ______________________

Emergency Contact: ______________________ **Phone:** (____) __________ **Relationship:** __________

Primary Care Physician: ______________________________ **Phone:** (____) ______________

Referred By: ______________________________

Reason For Today's Visit

Describe How This Injury Happened: ______________________________________

Is This Injury Auto ☐ **Workers Comp.** ☐ **Date of Injury:** ______________________

Have You Been To The Emergency Room For This?: ________ **If So, When?:** ______________

Have You Consulted Another Physician For This Problem?: ________ **If So, When?:** ______________

Have X-ray/MRI/CT Studies Been Taken?: ________ **If So, Where And When?:** ______________

••

Primary Insurance: ______________________ **ID #:** ______________ **Group #:** __________

Policyholder's Name: ______________________ **Policyholder's SS #:** ______________

Policyholder's Date of Birth: ______________ **Relationship To Patient:** ______________

Secondary Insurance: ______________________ **ID #:** ______________ **Group #:** __________

Policyholder's Name: ______________________ **Policyholder's SS #:** ______________

Policyholder's Date of Birth: ______________ **Relationship To Patient:** ______________

Medical Questionnaire — Orthopaedic Surgery

BP ____ / ____	Pulse ____
Temp. ____ Hgt. ____ / ____	Wgt. ____

Appointment Date ________ Chart # ________ Provider ________

Patient Name (Print) ________

Age ____ ☐ F ☐ M Dominant hand ☐ R ☐ L Did you bring x-rays? ☐ Y ☐ N

Who requested that you visit this office? (Name) ________ ☐ MD ☐ PA ☐ Attorney ☐ None (Self-Referral)

★ What is the main reason for this visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness ☐ Other ________ (C.C.)

★ What body part is involved? Please mark in table below. **If you have more than one, see receptionist.** (Location)

Neck ☐	and **radiates** to	☐ R arm ☐ L arm ☐ Neither	Shoulder	☐ R ☐ L	Elbow	☐ R ☐ L	Hand	☐ R ☐ L	Pelvis	☐ R ☐ L	Knee	☐ R ☐ L	Foot	☐ R ☐ L
Back ☐	and **radiates** to	☐ R leg ☐ L leg ☐ Neither	Arm	☐ R ☐ L	Wrist	☐ R ☐ L	Finger T 2 3 4 5	☐ R ☐ L	Hip	☐ R ☐ L	Ankle	☐ R ☐ L	Toe B 2 3 4 5	☐ R ☐ L

★ How long ago did it start? ___Days ___Weeks ___Months ___Years. Have you had a problem like this before? ☐ Y ☐ N (Duration)

In this section, check the ONE BOX which best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

ANSWER: COMMENTS

☐ **NO INJURY (Onset was:** ☐ Gradual or ☐ Sudden)
Why do you think it started? ________

☐ **INJURY - (☐ Accident ☐ Sport NOT Auto or Work)** ________
Date ________ . Where and How did it Happen? ________
What sport ________ School ________ ________

☐ **INJURY AT WORK** Date ________ . ________
From a ☐ lift ☐ twist ☐ fall ☐ bend ☐ pull ☐ reach ? ________

☐ **WORK RELATED - (BUT NO INJURY)** ________
Date ________ . How did your job cause this problem? ________

☐ **AUTO ACCIDENT** Date ________ . How was your car hit? ________ (Context)

★ **On a scale of 0-10 (10 is the worst) how severe** is your pain (circle) 0 1 2 3 4 5 6 7 8 9 10 (Severity)

★ What is the **quality** of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning (Quality)

The pain is ☐ Constant ☐ Comes and goes (Intermittent). **Does your pain wake you from sleep?** ☐ Yes ☐ No (Timing)

\+ Do you have? ☐ Swelling ☐ Bruise ☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of control of bowel or bladder (Assoc. Symp. or Neuro ROS)

Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged (Context)

What makes your symptoms **worse**? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting ☐ Lying in bed (Modify)
☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sitting ☐ Coughing ☐ Sneezing

Which make your symptoms **better**? ☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ Other ________ (Modify)

What medications are you taking now (or previously) for this problem? ________ (Modify)

Have you had any of these treatments? Injection ☐ Y ☐ N Brace ☐ Y ☐ N Physical Therapy ☐ Y ☐ N Cane/Crutches ☐ Y ☐ N (Modify)

Were you seen in the E.R. for this problem? ☐ Y ☐ N Which E.R. ________ Date ________

Are you here today as a result of the E.R. visit? ☐ Y ☐ N. Who saw you in the E.R. (name) ________ ☐ MD ☐ PA

What tests/scans have you had for this problem? ☐ X-Rays ☐ MRI ☐ CAT scan ☐ Bone scan ☐ Nerve Test (EMG/NCV)

Have you already had surgery for a problem in this same area either recently or in the past? ☐ Y ☐ N Please list below.

Procedure # 1 ________ Surgeon ________ City ________ date ________

Procedure # 2 ________ Surgeon ________ City ________ date ________

Current work status? ☐ Regular ☐ Light duty (How long? ________) ☐ Not working due to this problem ☐ Disabled ☐ Retired ☐ Student

When is the last date you worked your regular job. ________ P

Are you currently receiving or plan to apply for: Disability ☐ Y ☐ N Workman's Comp. ☐ Y ☐ N Unemployment ☐ Y ☐ N

NAME: MRN: Appointment Date

★ **REVIEW OF SYSTEMS:**

Have you had a **prior** problem with this same Orthopaedic condition in the past? ☐ Y ☐ N

Explain:

CIRCLE ANY CONDITION BELOW THAT YOU HAVE				OR CHECK NONE	Describe
MS	Joint Pain	Joint Stiffness		☐	
GI	Heartburn Ulcers	Nausea Vomiting	Blood in stool	☐	
ENDO	Frequent Thirst	Frequent Urination	Always Hot or Cold	☐	
CONST	Weight Loss	Frequent Fever	Loss of appetite	☐	
EYE	Blurred Vision	Double Vision	Vision loss	☐	
ENT	Hearing Loss	Hoarseness	Trouble swallowing	☐	
C-VASC	Chest Pain	Palpitations		☐	
RESP	Chronic Cough	Shortness of Breath		☐	
GU	Painful Urination	Blood in Urine	Kidney Problems	☐	
SKIN	Frequent Rashes	Skin Ulcers	Psoriasis	☐	
NEURO	Headaches	Dizziness	Seizures	☐	
PSYCH	Drug / Alcohol Problem	Depression	Sleep Disorder	☐	
HEME	Easy bleeding	HIV / AIDS	Hemophilia	☐	

ALLERGY Do you have **ALLERGIES** to medications? ☐ Y ☐ N If **YES, LIST ALLERGIES TO MEDICINE BELOW**

★ **PAST MEDICAL HISTORY** WHAT **MEDICATIONS** DO YOU TAKE? ☐ None Please list below with dosage.

Are you a Diabetic? ☐ **Y** ☐ **N** **TREATMENT:** ☐ **Insulin** ☐ **Oral Meds** ☐ **Diet** ☐ **None**

HAVE YOU EVER HAD? : Circle any conditions below: ☐ **I do not have any of the conditions listed below**

Asthma	Kidney Failure	Heart failure	Osteoporosis
Aspirin sensitivity	Hepatitis	COPD	Gout
Stomach ulcers	Liver Disease	Stroke	Back Pain
Bleeding ulcers	Heart attack (year)	Cancer (location)	Fracture Which bone?
Sulfa allergy	High Blood Pressure	Rheumatoid Arthritis	**Notes:**

Stomachache taking anti-inflammatories (NSAIDS) Which NSAIDS?

Blood Clots that you had to take blood thinners to treat? ☐ Y ☐ N When?

PAST SURGICAL HISTORY:

What operations have you had? When? ☐ **None** ______

Have you ever had a reaction to anesthesia? ☐ Y ☐ N

PAST HOSPITALIZATIONS (Not for surgery) ☐ **None** ______

★ **FAMILY HISTORY:** **Have any direct relatives had any of the following disorders? If so, which relative?**

☐ Hemophilia ______ ☐ High Blood Pressure ______ ☐ Diabetes ______ ☐ Rheumatoid Arthritis ______ ☐ **None**

Do any direct relatives have the same condition you are being seen for today? ☐ Y ☐ N Relationship

★ **SOCIAL HISTORY:**

Do you use tobacco? ☐ Y ☐ N **Packs per day** ______ Alcohol use: ☐ None ☐ Social ☐ Daily ☐ Frequently

Marital Status: M S D W How many people live with you? ______

Occupation: ______ ☐ Student Employer: ______

Do you like your job? ☐ Y ☐ N Do you plan to be working 6 months from now? ☐ Y ☐ N

PLEASE SIGN: The information on these two forms is accurate to the best of my knowledge. ______

For Office Use Only

Complete ______ Date ___/___/___ Review # 1 by______ MD Date ___/___/___ Review # 2 by______ MD Date ___/___/___

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PATIENT POLICIES

Prescription Refills

Prescription refills may be phoned in during business hours – 8:00 a.m. to 4:30 p.m. Monday through Friday. My pharmacy will be called each afternoon between 4:30 and 5:00 p.m. It is important I contact this office at least 2 days before my medication runs out to allow sufficient time for you and my pharmacy to refill my prescription.

Completion of Forms

Charges will be incurred for completion of special forms and reports, such as life insurance, disability, and so forth. Payment in full will be collected when the form is received. Please allow five business days for completion.

Privacy Practices

My signature confirms I was given a copy of OASA "Notice of Privacy Practices" as required under the Health Insurance Portability and Accountability Act (HIPAA).

Assignment of Benefits

My signature, or legal guardian's, permits OASA to bill and accept payment from my health plan, Workers' Compensation, Auto Insurance, Homeowners, Attorney, or other agency or facility paying my claims for medical services and items received by me. The remaining unpaid portion of my claims is my financial responsibility. I will pay co-payments at time of service per my insurance contract. OASA offers Care Credit for a payment plan. If a payment plan is not established, or payment has not been made within 120 days, my account will be turned over to a collection agency. I will be responsible for collection fees as appropriate under State of Florida regulations.

Consent for care and treatment

I hereby give consent for medical care and treatment, along with braces, splints, and other items related to my care, as provided by Orthopaedic Associates.

Date ______________________________

Patient ______________________________ Parent/Guardian ______________________________

Print Name ______________________________ Print Name ______________________________

One Orthopaedic Place • St. Augustine, FL 32086
Telephone (904) 825-0540 • Fax (904) 825-2490
www.oastaug.com

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Notice of Privacy Practices

Effective January 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read this carefully.

Your Health Information & Rights

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information is referred to as your health or medical record. This Notice of Privacy Practices describes how we may use or disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.

Although your health record is the property of this practice, the information belongs to you. You have the right to:

1. Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
2. Obtain a paper copy of this notice of privacy practices
3. Inspect and request a copy of your medical record as provided for in 45 CFR 164.524
4. Amend your health record as provided in 45 CFR 164.526
5. Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
6. Request communications of your health information by alternative means or locations

Orthopaedic Associates of St. Augustine's Responsibilities:

1. Maintain the privacy of your health information
2. Provide you with this notice as to our legal duties and privacy practices with respect to your health information
3. Abide by the terms of this notice
4. Notify you if we are unable to agree to a requested restriction

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. The current Notice of Privacy Practices can be reviewed by accessing our website at: www.oastaug.com, or by calling and requesting that a revised copy be sent to you in the mail. We will not use or disclose your health information without your authorization, except as described in this notice.

For more information or to report a problem –

If you have questions and would like additional information, you may contact our Privacy Officer or the Administrative Director for our practice by calling 904-825-0540. If you believe your privacy rights have been violated, you can file a complaint with the secretary of Health and Human Services. There will no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Care Operations:

Orthopaedic Associates of St. Augustine will use your health information for treatment. Your health information may be released to other healthcare professionals within the hospital and the community for the purpose of providing you with quality healthcare. For example: Information obtained by one of our staff including physicians, nurses and administrative staff will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your physician or a subsequent healthcare provider, such as a nursing home, home health care agency or physical therapy office, with copies of various reports that will assist them in treating outside of this office.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, tests and supplies used in the course of your care in our office.

We will use your health information for regular health operations. For example: Members of the medical staff and quality improvement teams may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service our office provides.

If you understand the above notice and information contained within, we ask that you sign and date that you acknowledge receipt of this information from our office. We will keep a copy of this signed notice in your medical record and provide you a copy for your own records. Thank you.

One Orthopaedic Place • St. Augustine, FL 32086
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Other Disclosures

Business Associates: There are some services provided in our clinic through contracts with business associates. Examples include physician services in the emergency department and radiology, certain lab tests, transcription services and billing companies. Through a signed agreement, we require all business associates to comply with HIPAA laws and requirements to safeguard your health information.

Notification: We may use or disclose information to notify a family member, personal representative, or another person responsible for your care, your location and general condition.

Communication with family: Our staff, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Food & Drug Administration: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized to comply with Florida laws relating to the workers compensation program.

Public Health: As required by Florida law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Communicable Disease: We may disclose health information as required by Florida law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Abuse or Neglect: We may disclose health information to a health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental agency authorized to receive such information.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing & Patient Satisfaction Surveys: We may contact you to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you. We may also contact you to obtain your opinion about our services.

Law Enforcement: We may disclose health information for law enforcement purposes as required by Florida law or in response to a valid subpoena or court order.

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Military & Veterans: If you are a member of the armed services, we may disclose health information as required by military command authorities.

______________________________________ ______________

Signature of Patient or Legal Representative Date

______________________________________ ______________

If signed by Legal Representative, Relationship to Patient Witness

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DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties listed below to request and receive the release of any Protected Health Information (PHI) regarding my treatment, payment or administrative operations related to treatment or payment. I understand that the identity of designated parties must be verified before the release of any information by providing proof of identification (i.e. Photo ID; SS card). This includes immediate family members (i.e. Spouse, Child, Parent).

Authorized Designees:

Name: ______________________ Relationship: ______________

Name: ______________________ Relationship: ______________

Name: ______________________ Relationship: ______________

Name: ______________________ Relationship: ______________

____
Patient Name

____
Patient Signature

____
Date

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