ORTHOPAEDIC ASSOCIATES OF ST. AUGUSTINE, P.A.
One Orthopaedic Place, St. Augustine, FL 32086

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**: _____

Soc Sec Number: _____-_____-_____ **Date of Birth**: _____/_____/_____

Address: _____ **Apt./Lot #**: _____

City: _____ **State**: _____ **Zip Code**:_____

Phone (H): (_____)_____ **(W)**: (_____)_____ **(Cell)**: (_____)_____

(Please complete the secondary address if you are not a full-time resident of this area.)

Secondary Address: _____ **Apt./Lot #**: _____ **Phone:** (____)_____

City: _____ **State**: _____ **Zip Code**:_____

E-mail Address: _____ **(If you would like to receive e-mails from our office)**

Employer (Parent's Employer if the patient is a minor/child): _____

Employer Phone: (____)_____ Position: _____

Emergency Contact: _____ **Phone**: (_____)_____ **Relationship**: _____

How did you hear about us? _____

Primary Care Physician: _____ **Phone**: (_____)_____

Referred by (Physician): _____

Is this injury from an Auto Accident? _____ **Date of Auto Accident:** _____**(OR)**

Is this injury covered under Worker's Comp? _____ **Date Of Injury:** _____

Have you consulted another Physician for this problem?: _____ **If so, whom?:** _____

Have you had an X-ray/MRI/CT Study done <u>for this problem</u>? Y / N

Please indicate what study you have had **<u>for this problem:</u>**

X-Ray ☐ Yes ☐ No Date Done: _____ What Facility? _____
MRI ☐ Yes ☐ No Date Done: _____ What Facility? _____
CT ☐ Yes ☐ No Date Done: _____ What Facility? _____

Primary Insurance: _____ **ID #:** _____ **Group #:** _____

Policyholder Name: _____ **Policyholder Soc Sec Number:** _____-_____-_____

Policyholder Date of Birth: _____/_____/_____ **Relationship To Patient:** _____

Secondary Insurance: _____ **ID #:** _____ **Group #:** _____

Policyholder Name: _____ **Policyholder Soc Sec Number:** _____-_____-_____

Policyholder Date of Birth: _____/_____/_____ **Relationship To Patient:** _____

PLEASE FILL OUT ALL FORMS IN THIS PACKET COMPLETELY