

Name: _____

PATIENT INFORMATION SHEET

Please Print

Today's Date _____

Are you here at the request of another physician? Yes No If yes, physician's name _____

Name of Family Physician (if different than above) _____

Patient's Name First: _____ Last: _____ SEX: M F Unknown Decline

DATE OF BIRTH _____ AGE _____ PATIENT'S SS# _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____ EMAIL _____

PREFERRED CONTACT METHOD FOR APPOINTMENT REMINDERS

Home phone Cell phone Work phone Mail Email Fax

HOME PH _____ WORK PH _____ CELL PH _____

RACE American Indian or Alaska Native Asian White

Native Hawaiian or Other Pacific Islander Black or African American Decline

ETHNICITY Hispanic or Latino Non Hispanic or Latino Decline

PREFERRED LANGUAGE _____ Decline

Employer _____ Ph _____

Employer Address _____ Occupation _____

City _____ State _____ Zip _____

PRIMARY INSURANCE

Insurance Company Name _____ Policy/Group # _____

Guarantor (if other than patient) _____ Date of Birth _____ SS# _____

Guarantor's Phone # _____ Insurance Claim Address _____

City _____ State _____ Zip _____

SECONDARY INSURANCE

Insurance Company Name _____ Policy/Group # _____

Guarantor (if other than patient) _____ Date of Birth _____ SS# _____

Guarantor's Phone # _____ Insurance Claim Address _____

City _____ State _____ Zip _____

NAME OF PERSON FINANCIALLY RESPONSIBLE FOR THIS BILL _____

Relationship to Patient _____ Drivers License # _____

Date of Birth _____ SS# _____

Has any member of your immediate family been treated by our physician(s) before? Yes No

If Yes, name of family member _____

If student, name of school _____

MARITAL STATUS: S M W D Sep Spouse's Date of Birth _____

Spouse's Name _____ Spouse's SS# _____

Employer _____ Ph _____

Emergency Contact Name _____ Ph _____ Relationship _____

IF ON THE JOB INJURY (WORKERS' COMPENSATION), COMPLETE THE FOLLOWING:

Has notice of injury been filed by employer? Yes No Date of injury _____

Employer at time of injury _____ Ph _____

Employer Address _____

City _____ State _____ Zip _____

Work Comp Carrier _____ Ph _____

Address for Claims _____

City _____ State _____ Zip _____

Name: _____

PATIENT HISTORY

Today's date _____ Age _____ Hand dominance: Are you right-handed left-handed
What medical problem brought you to see the doctor today? Which body part is affected? What side?

Does the pain travel to other areas? Yes No Where? _____

What makes the symptoms better? _____

What makes the symptoms worse? _____

Date symptoms started _____ Problems caused by injury or accident? Yes No

Where did injury occur: _____

Details of accident: _____

If open wound, date of last tetanus: _____

Previous treatment for injury/illness stated above that you are being seen for today:

Emergency room: Yes No Where? _____

Doctor's office: Yes No Name of doctor _____

What treatment was prescribed for this problem? (please check all that apply)

EXERCISE CAST BRACE SPLINT SLING DIET REST ELEVATION
 CRUTCHES OTHER TREATMENT: _____

Have X-Rays, MRI's CT's or any other diagnostic test been performed for this injury? Yes No

If yes, which test was performed? _____

Previous problems of a similar nature: _____

Doctor's NOTES: _____

MEDICAL HISTORY/REVIEW OF SYSTEMS- Check the box that best describes your relationship to the listed health issues. Also check the Family History box if an immediate family member is or has been affected (parents, siblings or children.)

	None		Past		Present		Family History		CARDIAC			None	Past	Present	Y	N	
							Y	N									
CONSTITUTIONAL									Palpitations/Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Fever	<input type="checkbox"/>								Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Chills	<input type="checkbox"/>								High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Vascular Disease	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL								
Fatigue	<input type="checkbox"/>								Nausea	<input type="checkbox"/>		<input type="checkbox"/>					
CENTRAL NERVOUS SYSTEM									Vomiting	<input type="checkbox"/>		<input type="checkbox"/>					
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Headaches	<input type="checkbox"/>								Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Visual Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastroesophageal Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Internal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Numbness	<input type="checkbox"/>								Diarrhea	<input type="checkbox"/>		<input type="checkbox"/>					
RESPIRATORY									URINARY								
Cough	<input type="checkbox"/>			<input type="checkbox"/>					Pain / Difficulty Urinating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Shortness of Breath	<input type="checkbox"/>			<input type="checkbox"/>					Kidney Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	INTEGUMENTARY								
Sinus Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>		<input type="checkbox"/>					
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MUSCULOSKELETAL								
CARDIAC									Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
									Pain in Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Name: _____

MEDICAL HISTORY/REVIEW OF SYSTEMS (Continued)

ENDOCRINE	None	Past	Present	Family History	
				Y	N
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Thirst	<input type="checkbox"/>		<input type="checkbox"/>		

HEMATOLOGIC	None	Past	Present	Family History	
				Y	N
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clot/DVT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bruising	<input type="checkbox"/>		<input type="checkbox"/>		

SURGICAL PROCEDURES:

Have you had surgery in the past? Yes No

Indicate month and year in the blank next to any surgery you have had in the past.

_____ C-section	_____ Stomach	_____ Hernia Repair	_____ Kidney
_____ Ovaries	_____ Colon	_____ Heart	_____ Thyroid
_____ Uterus	_____ Gall bladder	_____ Appendix	_____ Prostate
_____ Breast	_____ Small Intestine	_____ Valve Replacement	_____ Tonsils
_____ Hysterectomy	_____ Splenectomy	_____ Vascular Surgery	_____ Back
_____ Other _____			

Any extremity surgery? If yes, please indicate which side by circling R or L next to the appropriate body part and provide the month and year of the surgery.

R or L **Shoulder** _____ R or L **Elbow** _____ R or L **Wrist** _____ R or L **Hand** _____
 R or L **Hip** _____ R or L **Knee** _____ R or L **Ankle** _____ R or L **Foot** _____

What type of surgery did you have? _____

MEDICATIONS:

Please provide your preferred pharmacy: _____

Please list all current medications (including prescribed, herbal, and over-the-counter) and doses. None

ALLERGIES:

Please check any allergies that apply to you:

- None Penicillin Sulfa Iodine Tetanus
 Other _____

Please check any complications from your allergy:

- Nausea Hives Rash Swollen Throat Difficulty Breathing
 Other _____

SOCIAL HISTORY:

Please check your response to - Do you live:

- Alone with Spouse with Family with Friend Other _____

Smoking Status/ Current every day smoker Current some day smoker Heavy tobacco smoker Smoker, current status unknown

Tobacco Use: Never smoker Former smoker Light tobacco smoker Unknown if ever smoked

Cigarettes: _____ packs/day _____ Start date Quit date: _____ years of use
 Other: _____ frequency/day _____ Start date Quit date: _____ years of use

Please indicate alcohol use: None Beer Wine Liquor

Do you drink? Daily Weekly Occasionally

Are you currently working? Yes No If no, last date of work _____

Please check your work status:

- Work at home Work at the office Retired Student Disabled
 Other _____

Type of work you perform: _____

Doctor's NOTES: _____

Reviewed / Physician's Signature _____ Date _____

Name: _____

SUPERCONFIDENTIAL INFORMATION

PAST MEDICAL HISTORY Please check any disease diagnosed at any time - Items left blank indicate a negative response.

- Alcoholism Depression / anxiety Other _____
- Hepatitis Controlled substance (Rx drugs) abuse Females Only -
- HIV / AIDS Illegal drug use Are you pregnant? Yes No Uncertain

CONSENT TO EXAMINATION / TREATMENT

INSURANCE ASSIGNMENT, RECORDS AUTHORIZATION AND INFORMATION ACKNOWLEDGEMENT

I HEREBY CONSENT TO EXAMINATION AND TREATMENT AS DEEMED NECESSARY BY THE ORTHOPAEDIC INSTITUTE AND ITS PHYSICIANS. I HEREBY AUTHORIZE THE ORTHOPAEDIC INSTITUTE AND ITS PHYSICIANS TO FURNISH PATIENT HEALTH INFORMATION CONCERNING MY RELEVANT MEDICAL HISTORY (INCLUDING BUT NOT LIMITED TO THE SUPERCONFIDENTIAL INFORMATION LISTED ABOVE) TO ANY OF THE FOLLOWING: OTHER HEALTHCARE PROVIDERS INVOLVED IN MY CARE, INSURANCE CARRIERS, ATTORNEYS AND ADJUSTORS. I HEREBY CONSENT TO THE USE AND RELEASE OF MY INFORMATION TO A PATIENT PORTAL, NATIONAL DATA REGISTRY, BACTES, SURVEYS, AND AUTOMATED TELEPHONIC AND EMAIL APPOINTMENT REMINDERS. I HEREBY ASSIGN TO THE ORTHOPAEDIC INSTITUTE AND ITS PHYSICIANS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY INSURANCE. I UNDERSTAND THAT THE ORTHOPAEDIC INSTITUTE COMPLIES WITH APPLICABLE FEDERAL CIVIL RIGHTS LAWS AND DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, AGE, DISABILITY, OR SEX. I ACKNOWLEDGE THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION IN THIS FORM IS ACCURATE AND COMPLETE.

SIGNATURE _____ DATE _____
 PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR) _____

AUTHORIZATION FOR MEDICARE BILLING PURPOSES
LIFETIME FILE (MEDICARE PATIENTS ONLY)

I hereby certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I hereby authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I hereby request that payment of authorized benefits be made on my behalf and hereby assign the benefits payable for physician services to the physician if he/she chooses to accept assignment.

PATIENT'S SIGNATURE _____ DATE _____

PARENTAL RELEASE (IF PATIENT IS A MINOR)

I, _____ (legal guardian's name), hereby authorize The Orthopaedic Institute and its physicians to release any or all patient health information including superconfidential information regarding my child to the person(s) listed below (Example: A relative or someone other than a legal guardian may accompany your child on a future appointment).

SIGNATURE _____ DATE _____

Name _____	Relationship to patient _____	Phone # _____
Name _____	Relationship to patient _____	Phone # _____
Name _____	Relationship to patient _____	Phone # _____

PATIENT RELEASE

I, _____ (patient's name), hereby authorize The Orthopaedic Institute and its physicians to release any or all of my patient health information including superconfidential information to the person(s) listed below (Example: A spouse or relative may be involved in billing and insurance inquiries or medication refills.)

SIGNATURE _____ DATE _____

Name _____	Relationship to patient _____	Phone # _____
Name _____	Relationship to patient _____	Phone # _____
Name _____	Relationship to patient _____	Phone # _____

Name: _____

PRESCRIPTION HISTORY CONSENT

I agree that The Orthopaedic Institute may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

PATIENT'S SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR) _____

PRIVACY NOTICE

In accordance with the Health Insurance Portability and Accountability Act, patients of TOI are entitled to and afforded the rights to privacy regarding their health related information as set forth under applicable law. A patient's Protected Health Information ("PHI") may only be released as authorized by this law. TOI will strive to ensure that patient information is used only for purposes authorized by the patient, including but not limited to patient treatment and payment operations, lawful subpoenas, and as otherwise required by law. Upon request we can provide you with a complete copy of our Privacy Policies.

Additionally, upon providing reasonable advance notice, patients have a right to review their medical records and furnish comments to their records during normal business hours. In addition, patients have the right to obtain information regarding entities to which Protected Health Information has been provided.

Moreover, patients have the right

- to be informed of any breach of their unprotected PHI;
- to have marketing communications made to them only if authorized by the patient; and
- to decline to have PHI delivered to health insurers if the patient pays for services in full without submitting a claim.

If you have any concerns or wish to file a complaint, please contact TOI's HIPAA Compliance Officer, at (352) 336-6000.

NONDISCRIMINATION STATEMENT

The Orthopaedic Institute complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Orthopaedic Institute does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Orthopaedic Institute provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreter, written information in other formats (large print, audio, accessible electronic formats, other formats). The Orthopaedic Institute provides free language services to people whose primary language is not English, such as: Qualified interpreters and Information written in other languages. If you need these services, contact the scheduling department at (353) 336-6000.

If you believe that The Orthopaedic Institute has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Corporate Compliance, at (352) 336-6000. You can file a grievance in person or by mail, fax, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

PATIENT'S SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR) _____