Patient 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 First Name _______________ Last Name _______________ SEX: ☐ M ☐ F ☐ Unknown ☐ Decline

DATE OF BIRTH ____/____/____ AGE ________ PATIENT'S SS# ______-______-______

MAILING ADDRESS____

CITY ___________________________ STATE ________ ZIP ________ EMAIL ________________________

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: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated 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.)

				Family History	
CONSTITUTIONAL	**None**	**Past**	**Present**	**Y**	**N**
Fever	☐		☐		
Chills	☐		☐		
Glaucoma	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Fatigue	☐		☐		
CENTRAL NERVOUS SYSTEM					
Stroke	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Headaches	☐		☐		
Visual Problems	☐	☐	☐		
Hearing Problems	☐	☐	☐		
Numbness	☐		☐		
RESPIRATORY					
Cough	☐		☐		
Shortness of Breath	☐		☐		
Asthma	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐
Sinus Infection	☐	☐	☐		
Pneumonia	☐	☐	☐		
Sleep Apnea	☐	☐	☐		
CARDIAC					
Heart Attack	☐	☐	☐	☐	☐
Heart Failure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Coronary Artery Disease	☐	☐	☐	☐	☐

CARDIAC	**None**	**Past**	**Present**	**Y**	**N**
Palpitations/Irregular Heart Beat	☐	☐	☐		
Chest Pain	☐	☐	☐		
High Blood Pressure	☐	☐	☐	☐	☐
Peripheral Vascular Disease	☐	☐	☐	☐	☐
GASTROINTESTINAL					
Nausea	☐		☐		
Vomiting	☐		☐		
Liver Disorder	☐	☐	☐	☐	☐
Intestinal Disorder	☐	☐	☐	☐	☐
Ulcers	☐	☐	☐		
Gastroesphageal Reflux	☐	☐	☐		
Internal Bleeding	☐	☐	☐		
Diarrhea	☐		☐		
URINARY					
Pain / Difficulty Urinating	☐	☐	☐		
Kidney Problem	☐	☐	☐	☐	☐
Prostate Enlargement	☐	☐	☐	☐	☐
INTEGUMENTARY					
Rashes	☐		☐		
Burns	☐	☐	☐		
MUSCULOSKELETAL					
Rheumatoid Arthritis	☐	☐	☐	☐	☐
Other Arthritis	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐		
Birth Defects	☐	☐			
Pain in Joints	☐	☐	☐		

Medical History/Review of Systems Continued on Page 3

Patient Name ________________________________

MEDICAL HISTORY/REVIEW OF SYSTEMS (Continued)

ENDOCRINE	None	Past	Present	Family History Y	Family History N
Diabetes	☐	☐	☐	☐	☐
Hyperthyroidism	☐	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐	☐
Excessive Thirst	☐		☐		

HEMATOLOGIC	None	Past	Present	Family History Y	Family History N
Anemia	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐
Sickle Cell Disease	☐	☐	☐	☐	☐
Blood Clot/DVT	☐	☐	☐	☐	☐
Bruising	☐		☐		

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/ Tobacco Use: ☐Current every day smoker ☐Current some day smoker ☐Heavy tobacco smoker ☐Smoker, current status unknown ☐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: ________________________________

Do you have an Advance Care Plan? ☐ Yes ☐ No If yes, surrogate decision maker is: ________________

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
☐ HIV / AIDS ☐ Illegal drug use

Females Only -
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, SHARECARE HEALTH DATA SERVICES, LLC, 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)____________________

*For Electronic Signatures:

By checking this box I understand that I am signing this document electronically and all of my electronic signatures constitute legal signatures under Florida law.