

ORTHOPAEDIC SPECIALTIES OF TAMPA BAY, P.A. PATIENT REGISTRATION FORM

PATIENT NAME: _____ **TODAYS'S DATE:** _____
Last First Middle Initial

ADDRESS: _____ **Apt. No.** _____

City: _____ **State:** _____ **Zip:** _____ **Home Phone:** _____

Cell Phone: _____ **Email Address:** _____

AGE: ____ **DATE OF BIRTH:** ____/____/____ **SOCIAL SECURITY NO:** ____-____-____ **SEX:** M F

RACE: _____ **CIRCLE ONE:** SINGLE MARRIED WIDOWED SEPARATED DIVORCED CHILD

Employer of Patient: _____ **Occupation:** _____

Business Phone: _____ **Business Address:** _____

Emergency Contact Person: _____ **Phone:** _____

Relationship to Patient: _____

PRIMARY CARE PHYSICIAN: _____ **Phone:** _____

Address: _____

Name of Patient's Spouse: _____ **Social Security No.:** ____-____-____

Date of Birth: ____/____/____ **Employer:** _____ **Phone:** _____

PARENT OR GUARDIAN INFORMATION (If patient is a minor)

Name: _____ **Relationship:** _____ **D. O. B.:** ____/____/____

Address: _____

Street City State Zip

Employer: _____ **Phone:** _____

Social Security No.: ____-____-____

DIAGNOSTIC TEST: Please indicate which tests you have had in evaluation of your main complaint.

TEST	DATE	TEST	DATE
PLAIN X-RAYS		MRI	
BONE SCAN		ARTHROGRAM	
CT SCAN		EMG/NERVE CONDUCTION	
MYELOGRAM		OTHER:	

INJURY OR CONDITION:

Reason for Visit: _____ **LEFT:** ____ **RIGHT:** ____

How long have you had this problem? _____

Is the reason for your visit caused by an injury? YES ___ NO ___ **Date of Accident or Injury:** _____

Where did it occur? AUTO ___ HOME ___ SCHOOL ___ WORK ___ OTHER: _____

How did it occur? _____

Were you treated in an Emergency Room? YES ___ NO ___ **Which Hospital:** _____

Date: ____/____/____

Who referred you to our office: Primary Care Physician ___ Emergency Room ___ Friend ___ Family ___

Ad ___ Patient ___ Attorney ___ Adjuster ___ Insurance Book ___ Other: _____

FAMILY AND SOCIAL HISTORY:

Do you smoke or use tobacco? _____ #packs/day: _____ # years: _____ Quit/When: _____

Do you drink alcohol? None _____ Occasionally _____ Daily _____

Do you have a history of substance abuse? _____

Is there any family history of disease? _____ If so please list: _____

MEDICAL HISTORY REVIEW: Do YOU now have or have you ever had: (If Yes please Circle)

YES	NO	
		Lung Disease: Asthma Bronchitis Emphysema Shortness of Breath on Exertion
		Heart Attack Chest Pain Heart Failure
		Palpitations / Slow or Fast Heartbeat / Irregular Heartbeat
		Heart Valve
		Rheumatic Heart Disease
		Pacemaker / A.I.C.D. (Company Name: _____)
		High Blood Pressure
		Liver Trouble – Jaundice / Hepatitis
		Kidney Trouble
		Diabetes
		Thyroid Trouble
		Bleeding From Nose or Gums
		Easy Bruising
		Anemia
		Sickle Cell Disease
		Stroke TIA
		Seizures
		Tremors or Parkinson's
		Paralysis, Weakness of Arm or Leg
		Double Vision / Weak Eye Muscles
		Acid Indigestion or Hiatal Hernia / Ulcers / Stomach Problems
		Communicable Disease Exposure
		Tuberculosis
		Night Sweats
		Do you use recreational drugs or diet pills?
		Bowel Disorders
		Cancer Type: _____
		Depression
		Polio
		Rheumatism
		History of Hepatitis, Tuberculosis or HIV Infection
		Allergies to any type of metal
		Recent fevers or chills
		Bowel or Bladder problems
		Progressive Numbness or Weakness
		WOMEN: Is there a chance that you could be pregnant?

The information that I have provided is accurate and complete to the best of my knowledge._____
Signature of Patient or Guardian_____
Date_____
Physician's Signature

DRUG ALLERGIES:

NAME OF DRUG:	PLEASE DESCRIBE REACTION:
1.	
2.	
3.	
4.	

Do you have any allergies to anything other than medications? If so, please list (suture, pollen, tapes, metals, etc.)

DAILY MEDICATIONS:

NAME OF MEDICATION:	DOSAGE:	HOW OFTEN TAKEN:
1.		
2.		
3.		
4.		
5.		
6.		
7.		

MEDICAL ILLNESSES AND SIGNIFICANT INJURIES:

PLEASE LIST ALL MEDICAL ILLNESSES & INJURIES:	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.
	11.

PREVIOUS SURGERY: Please list ALL past operations of ANY KIND

TYPE OF SURGERY:	DATE:	SURGEON:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

INSURANCE INFORMATION:

PRIMARY Insurance Company	ID Number	Group/Policy Number	Phone
Claims Mailing Address	City	State	Zip
Name of Insured	Insured's SS No.	Relationship to Patient	Insured's DOB Sex: ?M ?F
Insured's Employer Name and Address	Coverage Effective Date	Coverage Termination Date	
SECONDARY Insurance Company	ID Number	Group/Policy Number	Phone
Claims Mailing Address	City	State	Zip
Name of Insured	Insured's SS No.	Relationship to Patient	Insured's DOB Sex: ?M ?F
Insured's Employer Name and Address	Coverage Effective Date	Coverage Termination Date	

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT
AND HEALTHCARE OPERATIONS

I, _____, understand that as a part of my health care, Orthopaedic Specialties of Tampa Bay, P.A. originates and maintains paper and/or electronic records and radiographs describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand and have been provided with the Orthopaedic Specialties of Tampa Bay, P.A. Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice of Privacy Practices prior to signing this consent,
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I further understand that Orthopaedic Specialties of Tampa Bay, P.A. reserves the right to change their Notice of Privacy Practices in accordance with the regulations outlined in the Federal Register. Should Orthopaedic Specialties of Tampa Bay, P.A. change their notice, I may request a copy of any revised notice.

I request the following restrictions to use or disclosure of my health information: _____

Please tell us with whom we may discuss the your/patient's treatment, payment or healthcare operations. Unless you so designate, we will not even be allowed to carry out simple tasks such as scheduling of appointments with anyone other than yourself/patient. Please check all that apply and supply names:

- Spouse: _____
- Child or Children: _____
- Parent: _____
- Grandparents: _____
- Siblings: _____
- Power of Attorney: _____
- Legal Guardian: _____
- Friend: _____
- Other (Please include relationship): _____

May we leave messages at your **home** using the doctor's or practices name? **Yes** **No**

May we leave messages on your **cell** phone using the doctor's or practices name? **Yes** **No**

May we leave a message at your **work** using the doctor's or practices name? **Yes** **No**

Do not leave a message

(Messages will be of a non-sensitive nature such as reminders for appointment referrals, etc.)

I understand that as part of treatment, payment or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and Accept / Decline (please circle one) the information of this consent.

Signature of Patient or Legally Authorized Representative

Printed Name of Patient or Legally Authorized Representative

Date



*GEORGE A. MORRIS III, M.D. • MICHAEL R. PIAZZA, M.D. • RICHARD V. ABDO, M.D.
W. ALLEN HUGHES, M.D., J. BYRON DAVIDSON, D.O., HOWARD SCHUELE, M.D.
ANTHONY L. MARCOTTE, D.O.*

PRACTICE FINANCIAL POLICY

- 1. Co-payments are collected as you check in for your appointment.**
- 2. All patient responsibility fees are due at the time services are rendered. Please make sure that you obtain a receipt for all cash payments. For your convenience we also accept Visa and Master Card.**
- 3. If you need special financial consideration, please speak with one of our billing specialists prior to seeing the doctor.**
- 4. If you belong to an insurance plan that requires prior authorization from a primary care physician or insurance company, it is your responsibility to make sure that authorization has been issued. If prior authorization is not issued from your primary care physician or insurance company, you will be personally responsible for the charges incurred.**
- 5. If you belong to an insurance plan with which we do not participate you will be personally responsible for payment in full at the time services are rendered. We will gladly assist you with the filing of claim forms for your reimbursement.**
- 6. If you are unable to pay in full at the time services are rendered we will require a signed payment agreement, guaranteeing payment.**
- 7. If your treatment is related to an auto accident and your regular health insurance is through a managed care plan, you must still obtain an authorization from your primary care physician or insurance company for treatment. If no authorization is obtained your managed care plan will not pay after your PIP benefits are exhausted, and you will be held responsible.**
- 8. In the case of divorced parents, responsibility for payment of a child's medical expenses incurred shall be that of the parent bringing the child in for treatment. In no case shall the other parent be billed unless financial arrangements have been made with that parent and we have legal documentation stating that they are the responsible party.**
- 9. There will be a minimum charge of \$25.00 for checks returned for non-sufficient funds. After receipt of a NSF check we reserve the right to require cash or money order for payment.**
- 10. In the event that you fail to pay patient responsibility account balances and we are forced to place your account with our attorney for collection, you will pay the attorney' fees and other costs incurred by us in collecting the amounts owed by you.**

This is the philosophy of our practice; however, we do reserve the right to amend this policy at any time.

Signature

Date

Witness

Date