



Highland Center for Orthopaedics PATIENT INFORMATION

PLEASE ANSWER ALL QUESTIONS FULLY

PATIENT						
NAME (Last, First, MI)		SOCIAL SECURITY	AGE	BIRTH DATE	SEX	HOME PHONE
MAILING ADDRESS		CITY	STATE	ZIP CODE	EMAIL ADDRESS	
SECONDARY MAILING ADDRESS		CITY	STATE	ZIP CODE		
EMPLOYER		CITY	STATE	ZIP CODE	WORK NUMBER	
DRIVER'S LICENSE NUMBER		STATE	NEAREST RELATIVE OR FRIEND'S NAME		PHONE NUMBER	
INSURANCE INFORMATION						
PRIMARY INSURANCE COMPANY		SUBSCRIBER'S NAME	RELATIONSHIP	POLICY #	GROUP #	
SUBSCRIBER'S DATE OF BIRTH		SUBSCRIBER'S SOCIAL SECURITY NUMBER				
EMPLOYER'S NAME		ADDRESS			PHONE NUMBER	
SECONDARY INSURANCE COMPANY		SUBSCRIBER'S NAME	RELATIONSHIP	POLICY #	GROUP #	
SUBSCRIBER'S DATE OF BIRTH		SUBSCRIBER'S SOCIAL SECURITY NUMBER				
EMPLOYER'S NAME		ADDRESS			PHONE NUMBER	
RESPONSIBLE PARTY						
NAME (Last, First, MI)		SOCIAL SECURITY	AGE	BIRTH DATE	SEX	HOME PHONE
MAILING ADDRESS		CITY	STATE	ZIP CODE	EMAIL ADDRESS	
EMPLOYER		CITY	STATE	ZIP CODE	WORK NUMBER	
DRIVER'S LICENSE NUMBER		STATE	NEAREST RELATIVE OR FRIEND'S NAME		PHONE NUMBER	
PRIMARY PHYSICIAN			REFERRING PHYSICIAN			
NAME		PHONE #	NAME		PHONE #	
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?						
INJURY INFORMATION						
NATURE OF INJURY/COMPLAINT				DATE OF INJURY/COMPLAINT		
IS THE INJURY WORK-RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO			AUTO INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO			
WHERE DID THE INJURY OCCUR?						
IS THERE AN ATTORNEY INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO		ATTORNEY NAME			PHONE#	
EMERGENCY CONTACT INFO - OTHER THAN SPOUSE - NAME			RELATIONSHIP		PHONE #	
PATIENT SIGNATURE					DATE	



**Patient Consent for Use and Disclosure
of Protected Health Information**

With my consent HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY, may use and disclose protected health information (PHI) about me to carry out treatment and healthcare operations (TPO). Please refer to HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have been given a copy of the Notice of Privacy Practices prior to signing this consent.

HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY reserves the right to revise its Notice Of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY. Privacy Officer at 2161 County Road 540 A #286, Lakeland, FL 33813.

With my consent, HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and may call pertaining to my clinical care, including laboratory results among others.

With my consent, HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as the are marked Personal and Confidential.

With my consent, HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY may e-mail to my home or the designated location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements and laboratory results. I have the right to request that HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, HIGHLAND CENTER FOR ORTHOPAEDICS AND UPPER EXTREMITY SURGERY may decline to provide treatment to me.

Please describe below any information you wish to not be released such as date(s) of service, level of detail to be released, orgin of information, etc.

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian



Highland Center for Orthopaedics

Authorization to Release Information

Surgery

If your physician recommends surgery, you will be escorted to his Surgery Coordinator. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it.

The Surgery coordinator will request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. A cost estimate which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan, will be explained by the Surgery Coordinator.

What if My Child Needs to See the Physician?

A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying is responsible for payment of the account, according to the policy outlined on the previous pages.

Authorization to Release Information and Assignment of Benefits

Consent to Treatment: I the undersigned, am the patient (or the duly authorized representative), and authorize care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgement of the attending physician, his/her assistants or designees.

Photographs/Video Tapes: I give consent for any photographs and/or video taping deemed necessary by my surgeon. I understand these photographs and/or video tapes are the property of my surgeon.

Assignment of Benefits: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private and group insurance or other health plan to the surgery center.

Release of Information: A photocopy of this assignment is to be considered as valid as an original and revocable by me only in writing. I hereby authorize said assignees to release all information to secure payment.

Financial Responsibility: I accept ultimate financial responsibility for accounts with the Highland Center whether paid by insurance or not. Please be advised that the estimate of your charge is based on the procedure(s) and information supplied by your physician's office at the time your procedure is scheduled. During your procedure, additional procedures may be necessary depending on the findings during the procedure. We will bill you or your insurance company for all the procedures and associated costs. You are obligated to pay any amount not covered by your verified insurance plans. This payment may be due prior to the procedure. If any unpaid balances should be sent to collections or an attorney, you will be responsible for all/any collection fees.

Date

Signature

Printed Name

This patient is a minor _____ years/months of age. The patient unable to sign above

_____ Legal Guardian initials

Witness:

Date

Signature

Printed Name

Medical Questionnaire

Orthopaedic Surgery

Appointment Date: _____ Chart # _____ Provider _____
 Patient Name (Print) _____

BP _____ / _____	Pulse _____
Temp. _____	Hgt _____ / _____ Wgt _____

Age _____ F M Dominant hand R L Height _____ / _____ Wgt _____ 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)

<input type="checkbox"/> Neck	and radiates to	<input type="checkbox"/> R arm <input type="checkbox"/> L arm <input type="checkbox"/> Neither	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Back	and radiates to	<input type="checkbox"/> R leg <input type="checkbox"/> L leg <input type="checkbox"/> Neither	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> R <input type="checkbox"/> L

r 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.

<input type="checkbox"/> NO INJURY (Onset was: <input type="checkbox"/> Gradual or <input type="checkbox"/> Sudden)	ANSWER:	COMMENTS
Why do you think it started?	_____	_____
<input type="checkbox"/> INJURY – (<input type="checkbox"/> Accident <input type="checkbox"/> Sport NOT Auto or Work)		
Date _____, Where and How did it Happen?	_____	_____
What sport _____ School _____	_____	_____
<input type="checkbox"/> INJURY AT WORK Date _____		
From a <input type="checkbox"/> lift <input type="checkbox"/> twist <input type="checkbox"/> fall <input type="checkbox"/> bend <input type="checkbox"/> pull <input type="checkbox"/> reach ?	_____	_____
<input type="checkbox"/> WORK RELATED – (BUT NO INJURY)		
Date _____, How did your job cause this problem?	_____	_____
<input type="checkbox"/> 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/Crutch 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. _____

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

Name _____

Appointment Date _____

REVIEW OF SYSTEMS:

1) M/S Have you had a prior problem with this same Orthopaedic condition in the past? Y N (explain below) _____

Do your other joints have morning stiffness lasting over 30 minutes Joint pain or swelling Back Pain Gout

Rheumatoid arthritis osteoporosis Prior fracture (which bone) _____ None of the above

Have you had a Bone Density Scan for Osteoporosis within 2 years? Y N . If no, ask receptionist for a Risk Screening Form

HAVE YOU HAD ANY OF THESE SYMPTOMS?, IF NOT, MARK NONE None Year Explain Details/Comments

2) GI Heartburn, ulcers Nausea, vomiting Blood in stool _____
 Hepatitis Liver disease _____

3) ENDO Thyroid disease Heat or Cold intolerance _____

4) CON weight loss Frequent Fever Loss of appetite _____

5) EYE Blurred vision Double Vision Vision loss _____

6) ENT Hearing Loss Hoarseness Trouble swallowing _____

7) CV Chest pain Palpitations _____

8) RS Chronic Cough Shortness of Breath _____

9) GU Painful Urination Blood in Urine Kidney problems _____

10) SK Frequent Rashes Skin Ulcers Lumps Psoriasis _____

11) NEU Headaches Dizziness Seizures _____

12) PSY Depression Drug/Alcohol addiction Sleep disorder _____

13) HEM Easy bleeding Easy bruising Anemia _____

14) ARE YOU ALLERGIC TO ANY MEDICATIONS? Y N If yes, please list and describe reaction _____

★ PAST MEDICAL HISTORY:

WHAT MEDICATIONS DO YOU TAKE? None Please list with dosage: _____

ARE YOU A DIABETIC? Y N TREATMENT: Insulin Oral Meds Diet None

ARE YOU TAKING, OR HAVE YOU EVER TAKEN, BLOOD THINNERS? Y N If yes, which one _____

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 _____

HAVE YOU EVER HAD: Heart attack (year) _____ High Blood Pressure Blood clots (year) _____ Stroke

Heart failure ankle swelling Kidney failure Asthma Sulfa allergy Aspirin sensitivity

stomach ulcers bleeding ulcers stomachache taking anti-inflammatories (includes Advil / Aleve)

What anti-inflammatories have you already had a problem with? _____

Cancer (location) _____ I do not have any of the above conditions

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

Diabetes _____ High Blood Pressure _____ Heart disease _____ Rheumatoid Arthritis _____ None

Do any direct relatives have the same condition you are being seen for today? Y N (relation to you) _____

★ SOCIAL HISTORY:

Do you use tobacco? Y N Packs per day _____ Alcohol use? Y N How often? Daily Other _____ / week

Marital History: M S D W How many people live with you? _____

Occupation: _____ Student Employer: _____

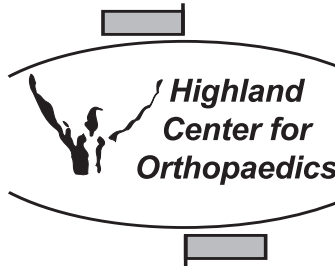
Do you like your job Y N Do you plan to be working 6 months from now? Y N

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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(863) 709-8777



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Lake Wales, Florida 33859
(863) 676-1571

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Patient Questionnaire

(PLEASE PRINT)

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Please complete for your chart. Please answer by putting a checkmark in the appropriate box.

RACE

- American Indian / Alaska Native
- Asian
- Black/African American
- Declined
- Nat Hawaiian / Pacific Islander
- Other Race
- White

RELIGION

- Buddhist
- Catholic
- Hindu
- Islam
- Jewish
- Protestant
- Other
- N/A

ETHNICITY

- Declined
- Hispanic or Latino
- Not Hispanic or Latino

PREFERRED COMMUNICATIONS

- Declined
- Email
- Fax
- Mail
- Patient Portal
- Phone
- Text