



# 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.

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\_\_\_\_\_  
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



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 \_\_\_\_/\_\_\_\_/\_\_\_\_