



# 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

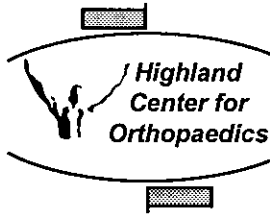
\_\_\_\_\_ Legal Guardian initials

Witness:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name



**Brian M. Jurbala, M.D.**

3317 U.S. Hwy. 98 S., Ste. 9

Lakeland, Florida 33803

863-709-8777

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## Credit Card Form

As you know, if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill.

This is an advantage for both you and the hotel or rental company since it makes checkout easier, faster and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion of your charges and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everyone in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Copays due at the time of the visit will, of course, still be due at the time of the visit. If you have any questions about this payment method, do not hesitate to ask us.

Print name as it appears on the card: \_\_\_\_\_

Please circle one:    Visa        Mastercard        American Express        Discover

Credit Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

# 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	<input type="checkbox"/> and radiates to	<input type="checkbox"/> R arm <input type="checkbox"/> L arm <input type="checkbox"/> Neither	<input type="checkbox"/> Shoulder	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Elbow	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Hand	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Pelvis	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Knee	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Foot	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Back	<input type="checkbox"/> and radiates to	<input type="checkbox"/> R leg <input type="checkbox"/> L leg <input type="checkbox"/> Neither	<input type="checkbox"/> Arm	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Wrist	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Finger T 2 3 4 5	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Hip	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Ankle	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Toe B 2 3 4 5	<input type="checkbox"/> R <input type="checkbox"/> L

† 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"/> <b>NO INJURY</b> (Onset was: <input type="checkbox"/> Gradual or <input type="checkbox"/> Sudden)	<b>ANSWER:</b>	<b>COMMENTS</b>
Why do you think it started?	_____	_____
<input type="checkbox"/> <b>INJURY</b> – ( <input type="checkbox"/> Accident <input type="checkbox"/> Sport <b>NOT</b> Auto or Work)		
Date _____, Where and How did it Happen?	_____	_____
What sport _____ School _____	_____	_____
<input type="checkbox"/> <b>INJURY AT WORK</b> 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"/> <b>WORK RELATED – (BUT NO INJURY)</b>		
Date _____, How did your job cause this problem?	_____	_____
<input type="checkbox"/> <b>AUTO ACCIDENT</b> 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 \_\_\_\_/\_\_\_\_/\_\_\_\_