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

NAME	PHONE #

REFERRING PHYSICIAN

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? ☐ YES ☐ NO AUTO INJURY? ☐ YES ☐ NO

WHERE DID THE INJURY OCCUR?

IS THERE AN ATTORNEY INVOLVED? ☐ YES ☐ NO	ATTORNEY NAME	PHONE#

EMERGENCY CONTACT INFO - OTHER THAN SPOUSE - NAME	RELATIONSHIP	PHONE #

PATIENT SIGNATURE	DATE

Highland Center for Orthopaedics

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 describle 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 herby 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)

Neck ☐	and radiates to	☐R arm ☐L arm ☐Neither	Shoulder	☐R ☐L	Elbow	☐R ☐L	Hand	☐R ☐L	Pelvis	☐R ☐L	Knee	☐R ☐L	Foot	☐R ☐L
Back ☐	and radiates to	☐R leg ☐L leg ☐Neither	Arm	☐R ☐L	Wrist	☐R ☐L	Finger T2345	☐R ☐L	Hip	☐R ☐L	Ankle	☐R ☐L	Toe B2345	☐R ☐L

ᵗ 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.

	ANSWER:	COMMENTS
☐**NO INJURY (Onset was:** ☐Gradual or ☐Sudden) Why do you think it started?		
☐**INJURY – (**☐**Accident** ☐**Sport NOT Auto or Work)** Date_____, Where and How did it Happen? What sport _____ School _____		
☐**INJURY AT WORK** Date_____, From a ☐lift ☐twist ☐fall ☐bend ☐pull ☐reach ?		
☐**WORK RELATED – (BUT NO INJURY)** Date_____,How did your job cause this problem?		
☐**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 ☐Bending ☐Squatting ☐Kneeling ☐Stairs ☐Sitting ☐Coughing ☐Sneezing (Modify)

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:

N2E3 (MS) **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

N3E4 (2+) 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	☐		
N4,5 E5 (10) **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 _____

_____

N3E4 (1) ★ **PAST MEDICAL HISTORY:**

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

N4,5 E5 (1) _____

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

N4,5 E5 (1) ★ **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)_____

N4,5 E5 (1) ★ **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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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