Today's date: _________________

Name:______________________________________ **Sex: M or F**

Date of birth_______________________________ **Age:** _______________________

Allergies: ____ **sw**______

Primary care physician____ **nite.**______

Why are you seeing the doctor today? Right or Left ________________________ **p/s**______

How long has this been bothering you?______________________________________ **pivt** ______

How were you injured, or how did your pain start?_________________________ **strs**______

____

o/h______

Have you seen another doctor for this? If so, what was done (surgery, x-rays, therapy, MRI, nerve conduction studies, shots, medicines?)__________________ **n/t**______

____

k/s_____

What medication are you taking for this problem?_________________________

When and exactly where does it bother you?_______________________________

____

What if anything makes it better or worse?______________________________

____

PAST MEDICAL HISTORY:

Surgeries/hospitalizations	Year	Complications

Current medications	What do you take this for?

Have you ever had general anesthesia?	**Yes**	**No**
Were there any problems with anesthesia?	**Yes**	**No**
Have you ever had a spinal anesthesia?	**Yes**	**No**
Were there any problems with your spinal?	**Yes**	**No**

Are you currently, or have you had problems, with your:

	Circle	Describe all yes responses
Eyes, Ears, Nose, Throat	NO YES	________________
Lungs, Breathing	NO YES	________________
Heart Problems	NO YES	________________
Bladder Problems	NO YES	________________
Diabetes	NO YES	________________
High Blood Pressure	NO YES	________________
Bleeding Problems	NO YES	________________
Balance Problems	NO YES	________________
Numbness/ Tingling	NO YES	________________
Blackout/ Fainting	NO YES	________________
Psychological Problems	NO YES	________________
AIDS	NO YES	________________
Cancer	NO YES	________________
Arthritis	NO YES	________________
TB	NO YES	________________
Epilepsy	NO YES	________________

Do you have a **family history** of any of the problems listed above? If so, which problem and family member's relationship to you?

____

SOCIAL HISTORY:

How often do you exercise?________________________________

What forms of exercise do you do?____________________________

Do you use recreational drugs (marijuana, cocaine, ecstasy?)________________

Do you smoke?________________ Packs per day___ for ______years

Quit smoking? This Year >1 year >5 years >10 years

Previously smoked? ______________ Packs per day _____for _____years

Drink Alcohol? Daily 1-2x/week 1-2x/month 1-2x/year

Patient Signature:______________________________Date:__________

Reviewed by:__________________________________ Date:__________

Patient Name:________________________________ Age:_____ Date of Birth_________

Patient Address:____ Zip Code___________

Home Phone________________ Social Security_________________________________

Occupation__________________ Employer_____________ Business Phone__________

Spouse's Name______________________ Spouse's Social Security_________________

IF PATIENT IS A MINOR:

Mother's Name__________________________ Mother's Employer_________________

Mother's SS#________________________ Mother's DOB__________

Mother's Work Phone____________________________

Father's Name_________________________ Father's Employer___________________

Father's SS#_______________________ Father's DOB___________________________

Father's work phone______________________________

PRIMARY INSURANCE COMPANY:

Insured's Name________________________________ SS#_______________DOB_____

Insured's Employer____________________________ Employer's Phone ____________

Patient's relationship to insured __________ Self__________ Spouse__________ Child

SECONDARY INSURANCE COMPANY:

Insured's Name________________________________SS#_______________DOB_____

Insured's Employer____________________________ Employer's Phone ____________

Patient's relationship to insured __________ Self__________ Spouse__________ Child

Thank you for choosing us for your health care needs and we appreciate the opportunity to serve you.

AUTHORIZATIONS AND ACKNOWLEDGEMENTS

AUTHORIZATION OF ASSINGNMENT OF BENEFITS:I hereby authorize Amelia Island Orthopedics to bill my insurance company directly for services rendered. I also hereby authorize payment to Amelia Island Orthopedics for any insurance benefits otherwise payable to me. I understand that I am financially responsible to Amelia Island Orthopedics for charges not covered by my insurance company. I hereby authorize Amelia Island Orthopedics to release to insurance carriers, federal or state agencies, employer, or their fiscal intermediaries, such as medical information as may be required or requested for the processing of claims for insurance, social security, or workman's compensation in connection with the medical care of the patient. This information may include, but is not limited to, information relating to psychiatric evaluation and treatment, sickle cell anemia, alcohol and drug abuse evaluation and treatment, HIV status, AIDS or AIDS related diagnosis, if any such information exists.

I certify that I have received a copy of this facility's financial policy and privacy notice (HIPAA) and that I have had an opportunity to review these documents and ask questions to assist me in understanding my rights relative to my financial responsibility and the protection of my health information. I am also satisfied with the explanation provided to me and I am confident that this facility is committed to protecting my health information.

Date:__________________ Signature:____

I certify that I am the authorized representative of _________________, and that I have received a copy of the financial policy and privacy notice. I am satisfied with the explanation provided to me about both.

Date:__________________Signature:____