ORTHOPAEDIC CARE SPECIALISTS
733 US HIGHWAY ONE
NORTH PALM BEACH, FL 33408

NAME _____

STREET _____APT _____

CITY _____STATE_____ZIP _____

DO YOU HAVE AN NORTHERN ADDRESS? ____YES _____NO (if so please provide on reverse side)

AGE _____SEX _____DATE OF BIRTH _____

HOME PHONE_____ CELL _____ WORK PHONE _____

EMAIL ADDRESS _____

PHARMACY NAME _____ PHONE _____

SOCIAL SECURITY_____ MARITAL STATUS: M S W D

SPOUSE'S NAME _____SPOUSE DATE OF BIRTH _____

NAME OF EMPLOYER_____

IS INJURY A RESULT OF:

MOTOR VEHICLE ACCIDENT? DATE _____
WORK RELATED ACCIDENT? DATE _____
OTHER ACCIDENT? DATE _____
(Please describe)

DO YOU HAVE MEDICAL INSURANCE? _____
(Please provide us with your card)

WHO IS YOUR MEDICAL DOCTOR? _____

MEDIGAP AUTHORIZATION
(FOR MEDICARE PATIENTS ONLY)

I request that payment of authorized MEDIGAP benefits be made on my behalf to ORTHOPAEDIC CARE SPECIALISTS for services furnished to me. I authorize any holder of medical information about me to release to my Medigap insurance company any information needed to determine these benefits or the benefits payable for related services.

_____

Signature Date

LIFETIME AUTHORIZATION
(FOR ALL PATIENTS)

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim.
I understand that I am financially responsible for all charges whether or not paid by said insurance.

_____

Signature Date

MEDICAL QUESTIONNAIRE

Patient _____ Date _____

WEIGHT _____ HEIGHT _____

Occupation: _____ Activities/Recreation: _____

Marital status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Smoking: ☐ No ☐ Yes (How much? _____ How Long? _____)

Alcohol: ☐ No ☐ Yes (Circle: Rarely / Socially / Daily / Other: _____)

Medications: (prescription/over the counter/supplement) ☐ No ☐ Yes

If yes, please list: (Name/Dosage) _____

_____

Allergies to medication/metals: ☐ No ☐ Yes (please list with reaction that occurred)

_____

Past Medical History: (check all that apply)

☐ Cancer	☐ Diabetes	☐ Hypertension	☐ Heart Disease
☐ Esophageal Reflux	☐ Fractures	☐ Rheumatoid Arthritis	☐ Gastric Ulcers
☐ Blood Clots/DVT	☐ Osteoarthritis	☐ Dental/Oral Problems	☐ Weight Changes
☐ Fever/Chills	☐ Headache	☐ Nausea/Vomiting	☐ Chest Pain
☐ Stroke	☐ Cough	☐ Chest Pain	☐ Incontinence
☐ Gout	☐ Hepatitis	☐ MRSA (recent)	☐ HIV/AIDS
☐ Bowel/bladder changes	☐Other: _____		

Surgical History: (check any that apply / date of surgery)

☐ Hernia repair _____ ☐ Pacemaker _____ ☐ Cholecystectomy _____

☐ Appendectomy _____ ☐ Tonsillectomy _____

☐ Orthopedic (surgery/year) _____

☐ Other: _____

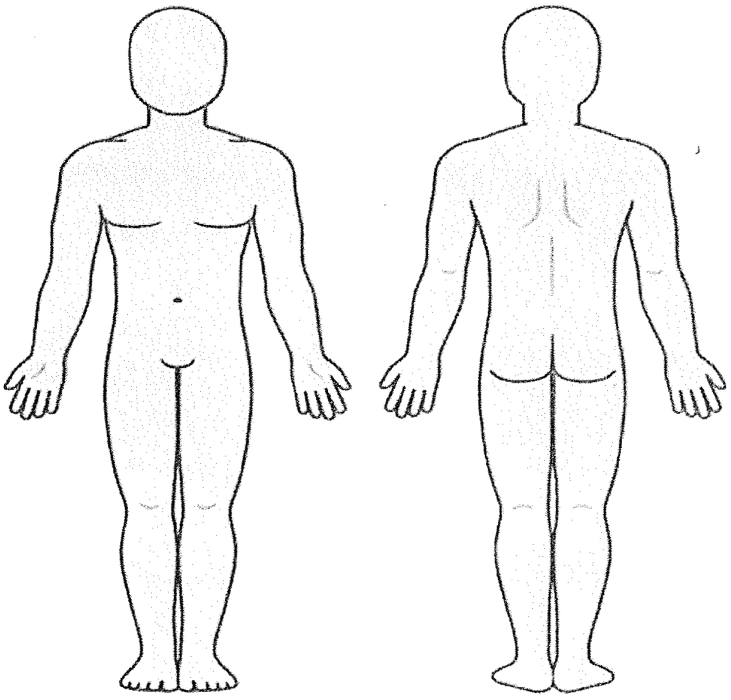
Family History: (check all that apply – family member not necessary)

☐ Stroke ☐ Heart disease ☐ Diabetes ☐ Cancer

☐ Osteoarthritis ☐ Bleeding disorder ☐ Other: _____

(PLEASE SEE OTHER SIDE)

(PLEASE MARK AREA OF PAIN WE ARE TREATING TODAY)



RIGHT LEFT / LEFT RIGHT

Pain Level: (circle one)

Best -- 1 2 3 4 5 6 7 8 9 10 -- Worst

When did the pain begin? _____ ☐ Days ☐ Weeks ☐ Years

Was this due to a car accident? ☐ No ☐ Yes (Date: _____)

Was there an injury? ☐ No ☐ Yes (Date: _____)

If yes, please explain: _____

Have you had any treatment? ☐ No ☐ Yes (if yes, see below)

Physical Therapy? ☐ N ☐ Y (When?_____ How long? _____)

Injections? ☐ N ☐ Y (Circle: Cortisone / Hyaluronic Acid (Gel) / Other)

If yes, when was your last injection? _____ ☐ Days ☐ Months ☐ Years

Other treatment: _____

Have you had any imaging? ☐ No ☐ Yes (Circle: X-ray / MRI / CT Scan / Other)

If yes, body part/when? _____

AGREEMENT OF PAYMENT FOR NON-PARTICIPATING PROVIDER AND PERSONAL FINANCIAL GUARANTEE

Patient's Name _____

Insured Name _____

Insurance Company _____

I understand that the doctors at Orthopaedic Care Specialists are not participating providers for my insurance plan. I agree that any insurance checks received by me (or insured/guarantor) for any services rendered, will be endorsed to Orthopaedic Care Specialists and sent within 10 business days.

I authorize Orthopaedic Care Specialists to be paid out of any settlement, judgement or verdict as it is necessary to adequately and completely reimburse provider for all medical treatment provided to me by any physician at Orthopaedic Care Specialists. I understand that I will remain responsible to the extent permissible under Florida law for the full amount of any balance on my account after partial payment from any source, such as, but not limited to PIP carriers, workers' compensation and any other insurance billed by Orthopaedic Care Specialists on behalf of the patient.

I realize that the balance of my medical bills is my responsibility whether or not my insurance company pays and is to be paid in full by me to the extent permissible under Florida law. For any services rendered by Orthopaedic Care Specialists arising out of an accident or event for which I receive any settlement, award or monetary recovery of any kind related to the injuries or conditions for which I am treated by Orthopaedic Care Specialists ("Recovery"), I agree and instruct any claims representative, attorney, adjuster, or insurance company to withhold from the proceeds of any Recovery sufficient funds to pay all outstanding medical charges of Orthopaedic Care Specialists. I understand and agree that I remain personally responsible for the full amount of my entire bill whether or not any Recovery is made. If partial payment is made to Orthopaedic Care Specialists for any Recovery, I agree that I am personally responsible to Orthopaedic Care Specialists for payment of the entire balance remaining on my medical bill after any partial payment from any source, to the extent permissible under Florida law. I agree that this personal financial guarantee and obligation to pay shall be binding upon myself, my heirs, executors, administrators, or personal and legal representatives of mine.

I hereby guarantee payment of all collection charges, including reasonable attorney's fees and court costs incurred in the event that collection action is necessitated due to the default of payment of said charges. If enforcement is necessary, I agree and acknowledge that this agreement shall be governed by the laws of the state of Florida and venue shall be the appropriate court of competent jurisdiction located in Palm Beach County Florida.

Patient/Guarantor Signature _____ Date _____

ORTHOPAEDIC CARE SPECIALISTS

733 US HIGHWAY ONE
NORTH PALM BEACH, FL 33408
PHONE: (561) 840-1090 FAX (561) 840-0791

CONSENT TO DISCUSS OR RELEASE INFORMATION
&
ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____ hereby give consent to ***Orthopaedic Care Specialists*** to discuss or release my private health care information to:

_____

☐ who is related to me ☐ is my care giver, unrelated to me

I fully understand and accept the terms of this consent. I have been informed of my rights according to HIPAA Regulations. I have reviewed and have had the opportunity to receive a copy of The *Notice of Privacy Practices at Orthopaedic Care Specialists*.

Signature _____ Date _____