



ORTHOPAEDIC ASSOCIATES OF ST. AUGUSTINE, P.A.

One Orthopaedic Place • St. Augustine, FL 32086
3055 CR 210 W, Unit # 110 • St. Johns, FL 32259
Ph (904) 825-0540 • Fax (904) 825-2490
www.oastaug.com

Welcome to our office. We are committed to providing you with the most comprehensive care possible. Please assist us in doing so by providing the following information, as well as your **driver's license and insurance card(s)**.

Last Name: _____ First Name: _____ Middle: _____

Soc Sec Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____

Primary Address: _____ Apt./Lot #: _____

City: _____ State: _____ Zip Code: _____

Phone (Home): (_____) _____ (Cell): (_____) _____

Employer (Parent's Employer if the patient is a minor/child): _____

Employer Phone: (_____) _____ Position: _____

Emergency Contact: _____ Phone: (_____) _____ Relationship: _____

(Please provide a secondary address if you are not a full-time resident of this area)

Secondary Address: _____ Apt./Lot #: _____ Phone: (_____) _____

City: _____ State: _____ Zip Code: _____

Primary Insurance: _____ Secondary Insurance: _____

Policyholder Name: _____ Policyholder Name: _____

Policyholder Date of Birth: _____ / _____ / _____ Policyholder Date of Birth: _____ / _____ / _____

Primary Care Physician: _____ Phone: (_____) _____

Referred by (Physician): _____

How did you hear about us? _____

PATIENT PRIVACY

I have read and understand the "Notice of Privacy Practices" posted in the lobby. A printed copy of the "Notice of Privacy Practices" is available upon request.

Patient / Guardian Signature _____

INDIVIDUALS AUTHORIZED TO RECEIVE MY MEDICAL INFORMATION

I hereby authorize the designated parties below to request and receive any Protected Health Information (PHI) regarding my treatment, payment, or administrative information related to my treatment or payment. I understand that the identity of designated parties must be verified before the release of any information by providing proof of identification (i.e. Photo ID). **If you would like your health information/PHI to be accessible to any immediate family members (i.e. spouse, child, parent), it is necessary to include them on the list below.**

Individuals Authorized to have access to my health information/PHI:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Print Patient Name

Patient / Guardian Signature

Date

Medical Questionnaire

Office Use Only:

Referred By: _____

Appointment Date _____ Chart # _____ Provider _____

Patient Name (Print) _____ DOB _____

Age ____ F M Dominant hand R L 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? _____

How long ago did it start? ____ Days ____ Weeks ____ Months ____ Years. Have you had a problem like this before? Y N

What body part is involved? Please mark in table below. **If more than one, see receptionist.**

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

Is this problem the result of an injury: Y ____ N ____

If no, was it a gradual onset ____ or sudden onset ____

If yes, you MUST complete below:

Where did injury occur _____

Date the injury occurred _____

How did the injury occur _____

Work related: Y ____ N ____

Auto related: Y ____ N ____

Driver ____ Passenger ____ Pedestrian ____

Type of vehicle _____

What did you hit/hit you _____

PROBLEM

On a scale of 0-10 (10 is the worst) how severe is your pain (write) 0 1 2 3 4 5 6 7 8 9 10

What is the **quality** of the pain? Sharp Dull Stabbing Throbbing Aching Burning

The pain is Constant Comes and goes (Intermittent). **Does your pain wake you from sleep?** Yes No

Do you have? Swelling Bruise Numbness Tingling Weakness Loss of control of bowel or bladder

Since my problem started, it is: Getting better Getting worse Unchanged

What makes your symptoms **worse**? Standing Walking Lifting Exercise Twisting Lying in bed

Bending Squatting Kneeling Stairs Sitting Coughing Sneezing

Which make your symptoms **better**? Rest Elevation Ice Heat Other _____

What medications have you taken for this current problem? _____

Are you in pain management? Y ____ N ____ Pain management physician's name _____

Have you had any of these treatments? Injection Y N Brace Y N Physical Therapy Y N Cane/Crutches Y N

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 ____ EMG/NCS ____

Where were these tests done? _____

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 _____

When is the last date you worked your regular job? _____

Are you currently receiving or plan to apply for: Disability Y N Workers' Comp. Y N Unemployment Y N

PAIN

TREATMENT

NAME:

MRN:

Appointment Date

★ REVIEW OF SYSTEMS:

	CHECK ANY CONDITION BELOW THAT YOU HAVE	OR CHECK NONE		Describe
MS	Joint Pain	Joint Stiffness		
GI	Heartburn	Ulcers	Nausea Vomiting	Blood in stool
ENDO	Frequent Thirst	Frequent Urination	Always Hot or Cold	
CONST	Weight Loss	Frequent Fever	Loss of appetite	
EYE	Blurred Vision	Double Vision	Vision loss	
ENT	Hearing Loss	Hoarseness	Trouble swallowing	
C-VASC	Chest Pain	Palpitations		
RESP	Chronic Cough	Shortness of Breath	COPD Asthma	
GU	Painful Urination	Blood in Urine	Kidney Problems	
SKIN	Frequent Rashes	Skin Ulcers	Psoriasis	
NEURO	Headaches	Dizziness	Seizures	
PSYCH	Drug / Alcohol Problem	Depression	Sleep Disorder	
HEME	Easy bleeding	HIV / AIDS	Hemophilia	

Are you Diabetic? Y N TREATMENT: Insulin Oral Meds Diet None

HAVE YOU EVER HAD? : Check any conditions below: I do not have any of the conditions listed below

- | | | | |
|----------------------|-----------------|---------------------|----------------------|
| Back pain | Stomach ulcers | Liver disease | Stroke |
| Fracture which bone? | Bleeding ulcers | Heart attack | Cancer site _____ |
| Osteoporosis | Kidney failure | High blood pressure | Rheumatoid arthritis |
| Gout | Hepatitis | Heart failure | Lupus |

Blood Clots that you had to take blood thinners to treat? Y N When?

Allergy: Do you have ALLERGIES to any medications? Y N If yes, please list all and reaction

Name _____ reaction _____

Name _____ reaction _____

Name _____ reaction _____

What medications do you currently take? None please list all below

Medication _____ Dose _____ / Medication _____ Dose _____

Medication _____ Dose _____ / Medication _____ Dose _____

Medication _____ Dose _____ / Medication _____ Dose _____

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 _____

Family History: Is your father still living? Y N Is your mother still living? Y N

Has any direct relative had any of the following disorders? If so, which relative? _____

Hemophilia ____ High Blood Pressure ____ Diabetes ____ Rheumatoid Arthritis ____

Does any direct relative have the same condition you are being seen for today? Y N Relationship _____

Social History: Alcohol use: None ____ Social ____ Daily ____ Frequently ____ / Drug Use: None ____ Social ____ Daily ____ Frequently ____

Do you currently smoke? Y N packs per day ____ / Have you in the past? Y N Do you chew tobacco? Y N

Occupation: _____ Martial Status: M S D W

PLEASE SIGN: The information on these two forms are accurate to the best of my knowledge.

Signature _____ Date _____

For Office Use Only

Complete ____ Date ____ / ____ / ____ Review # 1 by _____ MD Date ____ / ____ / ____ Review # 2 by _____ MD Date ____ / ____ / ____



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PATIENT FINANCIAL AGREEMENT

Completion of Forms

Charges will be incurred for completion of special forms and reports, such as life insurance, disability, and so forth. Payment in full will be collected when the form is received. Please allow five business days for completion.

Assignment of Benefits

My signature, or legal guardian's, confirms that I have received Orthopaedic Associates' (OASA) Financial Policies pamphlet. It also permits OASA to bill and accept payment from my insurance plan, Attorney, or other agency paying my claims for medical services and items received by me. The remaining unpaid portion of my claims is my financial responsibility. I will pay co-payments at time of service per my insurance contract. Please refer to the OASA "Financial Policies" pamphlet for detailed information on all Financial Policies, as well as, payment plans and Care Credit.

Patient financial responsibility

The undersigned understands and agrees that he or she will be financially responsible to pay for any balance not covered by his or her insurance company. This is to include Deductibles, Co-pays and Co-insurance.

The undersigned, if uninsured, agrees to pay a **DEPOSIT** prior to the visit and be financially responsible for any remaining balance resulting from any and all visits.

The undersigned also agrees to be responsible for any costs incurred should the balance be placed with a third party for collections.

Consent for care and treatment

I hereby give consent for medical care and treatment, along with braces, splints, and other items related to my care, as provided by Orthopaedic Associates.

Date _____

Patient _____

Parent/Guardian _____

Print Name _____

Print Name _____



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Name: _____ **Account #:** _____ **Date:** _____

Preferred Language:

English Spanish Other

Race:

American Indian Asian Black / African American White
 Alaskan Native Pacific Islander decline

Ethnicity: Hispanic/Latino Not Hispanic/Latino decline

Pharmacy Preference:

Name _____

Location _____

Phone _____

How would you like to be contacted?

Mail Phone E-mail

Request access to your records via our patient portal

Email: _____

*EMAIL ADDRESS REQUIRED for portal access

Smoking Status - for patients 13 years and up

every day some days former smoker never smoked