ORTHOPAEDIC ASSOCIATES OF ST. AUGUSTINE, P.A.

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

Nursing Home and Assisted Living Patient Checklist

In order to perform the optimum care and service to your residents we require the following information be provided **prior** to receiving an evaluation with our medical staff. Please complete this form and fax to appropriate number below. After we receive the completed form our staff will call to schedule the patient's appointment.

1. Name of your facility: _____
2. Phone: #_____
3. Insurance information & copies of all insurance cards
4. Information sheet containing diagnosis and referring physician request for a consult, when appropriate
5. List of all current medications\drug allergies
6. Please complete form below and return with paperwork

MUST BRING COPIES OF RECENT X-RAYS - 2 AP LATERAL OF THE AFFECTED SITE(S) AND LABS

Location being seen at: Saint Augustine____☐____ CR 210____☐____
St Augustine fax # 904.209.1034 **CR 210 fax # 904.287.7876**
Reason for Visit to our Clinic_____
Is this Hospital Follow Up? Yes____☐____ No____☐____ If yes, date_____
What doctor do they need an appointment with_____
Will patient be arriving by stretcher? Yes____☐____ No____☐____

Name of Patient: _____
Address _____
Phone # _____ SS# _____ DOB _____
Emergency Contact _____ Relationship_____
Primary Ins. _____ Policy # _____
Policy Holders Name _____ Relationship _____
Secondary Ins. _____ Policy # _____
Policy Holders Name _____ Relationship_____
POWER OF ATTORNEY PAPERWORK MUST BE INCLUDED, IF APPLICABLE

Patient Signature _____ Date _____

Power of Attorney Signature _____ Date _____
Revised 9/14

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)

PROBLEM

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 ☐	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 T 2 3 4 5	☐ R ☐ L	Hip	☐ R ☐ L	Ankle	☐ R ☐ L	Toe B 2 3 4 5	☐ R ☐ 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 _____

PAIN

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

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 _____

TREATMENT

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 Workman's Comp. ☐ Y ☐ N Unemployment ☐ Y ☐ N

NAME: **MRN:** **Appointment Date**

★ **REVIEW OF SYSTEMS:**

	CIRCLE 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? : Circle 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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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

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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 Signature _____ Print Name _____

Guardian Signature _____ 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

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SureScripts Consent

In 2011 the Federal Government mandated that all providers submit their prescription requests to your pharmacy through electronic transmission. This is to ensure a safe, secure way to protect the privacy of your health information.
To comply with this mandate Orthopaedic Associates of St. Augustine is in the process of implementing ePrescribing at both of our locations.
ePrescribing not only ensures security in the transmission it also allows your physician to see important information such as drug interactions and your prescription history.

The benefits to you as the patient:

- Reduced chance of adverse drug interactions
- Reduced possibility of medical errors
- Fewer trips to the pharmacies to drop off a prescription
- The ability for the doctors to reconcile our records with the pharmacy for accuracy

Patient Consent:
I agree that Orthopaedic Associates of St. Augustine may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

_____ _____

Patient Signature Date