



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 # 904.217.7100 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

NAME:

MRN:

Appointment Date

★ REVIEW OF SYSTEMS:

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

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 ____/____/____



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



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

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 _____



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

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