Coastal Orthopaedic & Sports Medicine Center

NEW PATIENT REGISTRATION

Date of Visit: _____/_____/_____ **Office Use Only**: Account #:_____

Full Name: _____ **Date of Birth**: _____/_____/_____

Social Security #:_____-_____-_____ **Gender**: ☐ Male ☐ Female **Hand Dominance**: ☐ Left ☐ Right

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner

Race: ☐ African American ☐ Asian ☐ Caucasian
☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander
☐ Other:_____

Ethnicity: ☐ Hispanic ☐ Not Hispanic or Latino ☐ Other: _____

Employer: _____ **Occupation**: _____

Primary Care Physician: _____
Who referred you to us? ☐ Physician _____ ☐ Friend_____
Hospital—Please indicates which one: _____ ☐ Other _____

CONTACT INFORMATION

Mailing Address: _____ City: _____ State: _____ Zip Code:_____

Primary Contact Phone: _____ Secondary Contact Phone: _____

E-Mail:_____

Preferred Method of Contact: ☐ Patient Portal ☐ E-Mail ☐ Mail ☐ Mobile ☐ Phone

Would you like to receive e-mails on events our office may have? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone#:_____ Mobile #:_____

***Information below must be filled out completely and accurately in order for qualified RXs to be prescribed:**

Pharmacy Name: _____ Phone #:_____
Address (If phone # is not supplied):_____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES PERMISSION TO SHARE HEALTH INFORMATION

Patient Name: _____

I have **received a copy** of Coastal Orthopaedic & Sports Medicine Center's "Notice of Privacy Practices" on this day (posted in office). I hereby **authorize** Coastal Orthopaedic & Sports Medicine Center to disclose my health information to the following person(s):

NAME **RELATIONSHIP TO PATIENT**

_____

_____

_____

_____

I hereby request the following **restrictions** on the use and disclosure of my health information. The practice is not required to agree with my requests.

_____

_____

_____

By my signature below, I affirm the above information.

_____
Patient's Signature

_____
Date

DO YOU HAVE AN ADVANCED DIRECTIVE? ____ YES ____NO
DO YOU WANT TO PROVIDE A COPY OF THE ADVANCED DIRECTIVE? ____YES ____NO
DO YOU WANT TO DISCUSS YOUR ADVANCED DIRECTIVE? ____YES ____NO
WHO IS YOUR POWER OF ATTORNEY? NAME _____ PHONE _____

INSURANCE INFORMATION

Patient Name: _____ **Today's Date**: _____

If your visit is related to an injury **of any kind** please complete the below questions. Please answer all questions in detail if possible. Enter "N/A" if not applicable.

☐ Worker's Compensation ☐ Auto Accident ☐ Other Type of Accident ☐ Not an Accident

Please answer the following questions in order to provide your insurance company information to process claims for benefit for all types of accidents. If this form is not completely filled out, you may be responsible for any accrued balances. If your injury is due to an auto or workers compensation injury, this must be billed thorough auto or w/c insurance. Please stop and see receptionist if you have not provided us with this information yet.

1. **Brief description of accident:** (Please be specific as to the exact date, time and place if possible.)
Date of accident:

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ **Policy #**:_____

Policyholder's Name: _____ **Policy Holder DOB**: _____/_____/_____
Relationship to patient: ☐ Self ☐ Spouse ☐Child ☐ Other

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ **Policy #**:_____

Policyholder's Name: _____ **Policy Holder DOB:** _____/_____/_____
Relationship to patient: ☐ Self ☐ Spouse ☐Child ☐ Other

By my signature below, I affirm the above information.

_____
Patient's Signature

_____
Date

HEALTH HISTORY QUESTIONNAIRE

PATIENT INFORMATION

For office use only: To be completed every 6 months

Patient's Full Name: _____ Account # _____

DOB: _____ Height: _____ Weight: _____

CHIEF COMPLAINT: _____ ☐ RIGHT ☐ LEFT ☐ BILATERAL

Have you been treated for this problem before: ☐ Yes ☐ No

If yes, by whom? _____ Date of treatment: _____

PLEASE LIST ALLERGIES TO MEDICATION ☐ NONE

MEDICATION _____ **REACTION:** _____
MEDICATION _____ **REACTION:** _____
MEDICATION _____ **REACTION:** _____

MEDICATION _____ **REACTION** _____
MEDICATION _____ **REACTION** _____
MEDICATION _____ **REACTION** _____

PLEASE LIST ANY ALLERGIES TO METALS INCLUDING ANY JEWELRY AND/OR IMPLANTS

METAL _____ **REACTION:** _____
METAL _____ **REACTION:** _____

METAL _____ **REACTION**
METAL _____ **REACTION**

PAST MEDICAL HISTORY (Please check) ☐ NONE

☐Acid Reflux
☐Addiction
☐Alzheimer's Disease
☐Amputation
☐Angina
☐Arrhythmia
☐Atrial Fibrillation
☐Asthma
☐Back/Neck Problems
☐Bleeding Disorders
☐Blood Clot __RT__LT
☐Blood Transfusion
☐Blood Transfusion Reaction
☐Bowel disease
☐Bursitis
☐Cancer
Type: _____
Current Treatment: _____
Past Treatment: _____
☐Cerebral Palsy
☐Chest Pain
☐Chronic Obstructive Pulmonary Disease (COPD)
☐Constipation
☐Coronary Artery Bypass Graft (CABG)
☐Coronary Artery Disease (CAD)
☐Defibrillator
☐Dementia
☐Depression
☐Diabetes
☐Dialysis
☐Diverticulosis
☐Edema
☐Encephalitis
☐Endometriosis
☐Enlarged Prostate
☐Gout
☐Headaches
☐Heart Disease
☐Hematuria
☐Hepatitis
☐Hernia
☐High Blood Pressure
☐History of VRE
☐HIV/AIDS
☐Incontinence
☐Kidney Disease
☐Kidney Infections
☐Kidney Stones
☐Liver Disease
☐Lupus
☐Lyme Disease
☐Lymphedema
☐Mental Illness
☐Migraines
☐MRSA
☐Myocardial Infarction (MI)
☐Neck/back disorder
☐Osteoarthritis
☐Pacemaker
☐Paralysis
☐Parkinson's
☐Peripheral Vascular Disease (PVD)
☐Phlebitis
☐Pneumonia
☐Pressure Ulcer
☐Prior Anesthesia Complications
☐Rheumatoid Arthritis
☐Shortness of Breath
☐Sleep Apnea
☐Stoke/TIA
☐Thyroid Disease
☐Tuberculosis
☐Ulcers
☐Urinary Frequency
☐Urinary Tract Infection (UTI)
☐Urinary Retention
☐Valve Replacement
☐Vertigo
☐Weakness

☐Congestive Heart Failure

FAMILY HISTORY (Please check)

Please indicate which family member has any of the following conditions: ☐ **NONE**

(i.e. Mother, Father, Brother, Sister)

☐Addiction: _____ ☐Alcoholism: _____ ☐Rheumatoid Arthritis: _____

☐Bleeding DisOrder Radiology: _____ ☐Heart Disease: _____ ☐HIV/AIDS: _____

☐Hypertension: _____ ☐Kidney Disease: _____ ☐Mental Illness: _____

☐Stroke: _____ ☐Arthritis: _____ ☐Kidney Stones: _____

☐Other: _____ ☐Unknown ☐Adopted

SMOKING STATUS

☐Never Smoked ☐ Former Smoker ☐ Occasional Smoker

☐ Light -1-9 cigs/day ☐Moderate - 10-19- cigs/day ☐ Heavy -20-39 cigs/day ☐ Very Heavy - 40+ cigs/day

Do you use: ☐ Cigarettes ☐ Chewing Tobacco

SOCIAL HISTORY

Living Status: ☐ Lives Alone ☐ With Spouse ☐ Skilled Nursing ☐ With Other Family—Who? _____

Do you use alcohol? ☐Never ☐Occasional ☐Moderate ☐ Heavy ☐ Past Abuse

History of drug abuse? ☐Yes ☐No

Do you Exercise? ☐Less than 3 times a week ☐ More than 3 times a week ☐ Never

Employment Status: ☐Full Time ☐Part Time ☐Homemaker ☐Retired ☐Student ☐Unemployed ☐ Disabled

If female, are you pregnant? ☐ Yes ☐ No

SURGICAL HISTORY

☐ Appendix ☐ Fracture ☐Other:_____

☐ Back/Lumbar ☐ Gallbladder ***Prior Orthopaedic Surgeries**: ☐ Yes ☐ No

☐ Cancer ☐ Hysterectomy If yes, please specify body part and year of surgery:

☐ Cervical ☐ Prostate _____

MEDICATIONS

Please correctly spell the names of medications you are currently taking, or you may provide a list on a separate sheet of paper)

Name of Drug	Strength	Frequency Taken

******I attest that the information provided above is complete & accurate as it will be utilized as a part of my care and treatment plan. *******

_____ _____

Patients Name (Please Print) Date

_____

Patient's Signature (Parent's Signature if Minor)

WELCOME TO OUR PRACTICE

Please review a few of our office policies. If you would like a copy of this, please notify the receptionist:

PRESCRIPTION REFILLS

Refill request made after 12:00 p.m. will not be filled until the next business day. Additionally**,** by signing below you are authorizing Coastal Orthopaedic & Sports Medicine Center to electronically receive and review any prescription history available to the electronic health record.

It is our office policy that written prescriptions are only released to authorized individuals listed on the patient information sheet. If any other person (not listed) picks up a written prescription, we must have a signed consent from the patient notifying us of this. Copy of a picture ID is necessary in order to release the prescription.
WE WILL NOT RELEASE THE PRESCRIPTION WITHOUT WRITTEN CONSENT!

The on-call physician will not call in prescriptions on weekends, please call in advance for all refill requests. **Do not wait until you are completely out of medication.**

PAYMENT POLICY

Payment is expected at time of service unless prior arrangements have been made in advance.
Patients are responsible for paying their annual deductible, co-insurance payments and any non-covered service charges at the time of the visit. The office accepts MasterCard, Visa, Discover and American Express.

HMO OR MEDICARE REPLACEMENT PLANS

If you are enrolled in a HMO or Medicare Replacement Plan, it is your responsibility to notify the office staff before treatment. It is the responsibility of the patient to assure that the office staff has a referral/authorization on file for your visit and participates with the plan as a provider. Your signature below indicates you understand you may be financial responsibility for any claims rejected by the insurance carrier for reasons such as non-provider, no authorization, etc.

COPY REQUEST

Your records are the property of Coastal Orthopaedic & Sports Medicine Center. This includes X-rays or MRI's performed within our practice. However, we will be happy to provide you with a copy of your X-rays/MRI at a cost. The office requires a 24-hour advance notice if you need copies of medical records, x-rays or MRI's. **Please note our office has outsourced the request for all medical records to *Diversified Medical Record Service.* *When requesting medical records all patients will work directly with a representative from DMRS. Should you need to speak to DMRS concerning your request for medical records please contact them at 800-359-8520.***

FORMS

Forms can be submitted to the office for completion. This is an additional service that is provided for our patients. Therefore, there is an additional charge of $10 up to $25 depending on the form. Payment must be made in full before the form can be completed. Please allow adequate time for completion.

INSURANCE VERIFICATION

As a courtesy to you our staff will verify your benefits for your insurance/s for services provided at our office. Verification of benefits is not a guarantee of payment nor accurate benefits, only an estimate. It is the responsibility of the patient (parent if minor) to contact their insurance company directly to verify that all information provided to our office is accurate.

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Coastal Orthopaedic and Sports Medicine Center, Inc. (herein after referred to as the "practice") for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations.
I understand diagnosis or treatment of me by my treating physician may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment for healthcare operations of the practice. The practice agrees to a restriction that I request, the restriction is binding on Coastal Orthopaedic and Sports Medicine Center, Inc. and My Treating Physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that My Treating Physician and Coastal Orthopaedic and Sports Medicine Center, Inc. have taken action in reliance on this consent.

My "protected health information" means health information including demographic information, collected from me and created or received by physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or if there is a reasonable basis to believe that information may identify me.

I understand I have a right to review the practices Notice of Privacy Practices prior to signing this document. By signing this document, I acknowledge that the practices Notice of Privacy Practices has been provided to me and that I have had the opportunity to read, ask questions, get answers and get a copy to take with me if I so desire. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of the practice. The Notice of Privacy Practices also describes my right and the practice duties with respect to my protected health information.

I understand that the Physical Therapy performed at Coastal Orthopaedic and Sports Medicine Center, Inc. is generally performed in an open room. If I find the openness uncomfortable, the practice is happy to accommodate my request to be treated in a curtained area.

The practice reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a copy to be sent by mail or given at my next appointment.

I understand the above terms of the Office Policy and consent to use or disclose information of my protected health information.

Patient Name:

Signature of Patient or Parent (if Minor):_____

Office Use Only: Front Office: _____

ASSIGNMENT OF BENEFITS

I authorize *Coastal Orthopaedic and Sports Medicine Center, Inc.* to endorse checks and/or to sign any piece of paper which will enhance or expedite payment to providers for services rendered, including, but not limited to a release of medical records and assignment of benefits/authorization to pay.

I, (Name of Insured/Patient) Hereby Authorize Primary Insurance Company: (Name of Auto or Health Ins.Carrier)

to make medical benefits payments otherwise payable to me for services rendered by *Coastal Orthopaedic and Sports Medicine Center, Inc.* but not to exceed the charges of those services, payable to and mailed directly to:

COASTAL ORTHOPAEDIC & SPORTS MEDICINE CENTER
7710 S. US HIGHWAY ONE
PORT ST. LUCIE, FL 34952

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I understand that payment of charges incurred is due at the time of service unless financial agreements have been made prior to treatment***. I also authorize Coastal Orthopaedic and Sports Medicine Center, Inc. to charge my account $25.00 if co-payments, deductibles, etc. are not paid on the same day services are rendered.*** I agree to pay for all reasonable attorney fees and reasonable collection cost in the event of default payment for services rendered. I further authorize and request that insurance payments be made directly to *Coastal Orthopaedic and Sports Medicine Center, Inc.* I understand that the office files to my insurance carrier/s for insurance reimbursement as a courtesy, and failure on the part of the insurer to make payment shall not relieve me of my obligation to pay any balance due to *Coastal Orthopaedic and Sports Medicine Center, Inc.*

I have read and fully understand the above financial responsibility and insurance authorization. I have read all the information on this sheet. I certify that all the information in this packet is true and correct to the best of my knowledge. I will notify you of any changes in my status or information given.

Patient Name: _____

Parent or Guardian Signature (if Minor): _____

Office use only:

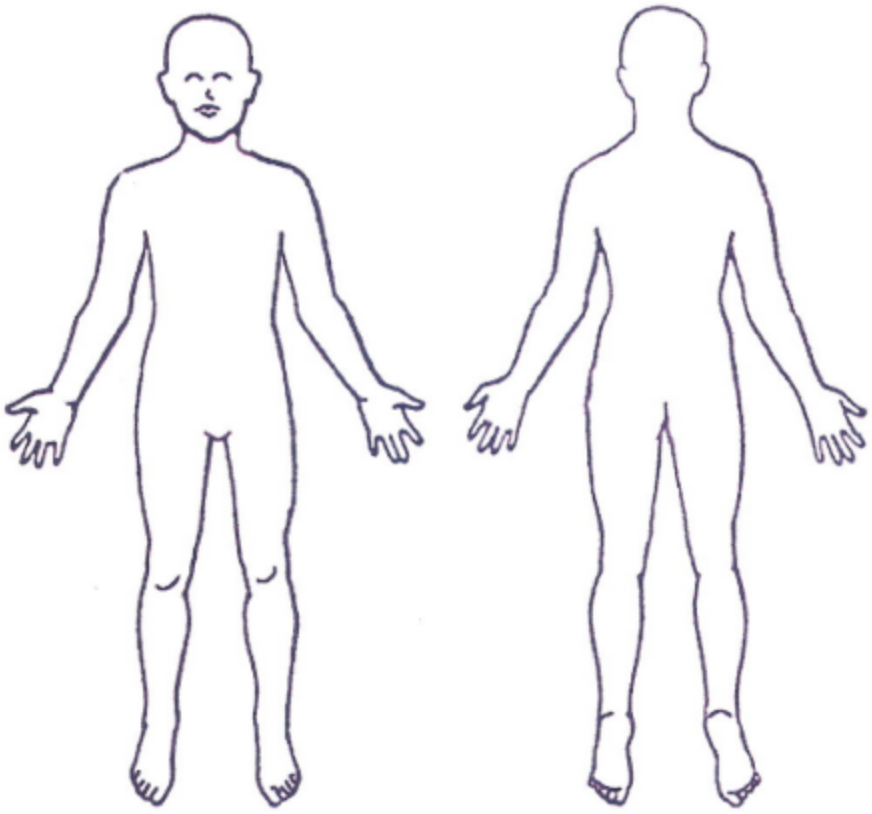
Front Office: _____

Patient Name: _____ DOB: _____ Today's Date: _____

Using the symbols below, mark the areas on your body (for which you are being seen for today) where you feel the following described sensations:

N= NUMBNESS **PN= PINS AND NEEDLES** **B= BURNING**
S= STABBING **A= ACHE**

RIGHT **LEFT** **LEFT** **RIGHT**



FRONT **BACK**

_____ _____
Patient Signature (Parent if Minor) Date