South Florida Hand and Orthopaedic Center

Date ____________________

Patient's Last Name ______________________ First Name ______________________ Initial ______

Local Address ____
(Street) (Apt #) (City) (State) (Zip)

Permanent Address ____
(Street) (Apt #) (City) (State) (Zip)

Home Phone ( ) ____________ Date of Birth ________ Age ____ Sex ____ S.S.# ____________

Work Phone ( ) ____________ Marital Status ____________ Spouse's Name ____________

Employer Name and Address ____

Spouse's Employer Name and Address ____

Referred By ______________________ **Family Physician (P.C.P.)** ______________________

Approximate Height ______________________ Approximate Weight ______________________

Date Illness/Injury Began ______________________ Is this Related to your Employment? Yes ____ No ____

If Injury, Type ________ Auto Accident ________ At Work ________ Other Accident

Describe Symptoms ____

Primary Insurance Company ____

Primary Policy Holder's Name ______________________ Date of Birth ____________

Secondary Insurance Company ____

Secondary Policy Holder's Name ______________________ Date of Birth ____________

Current Medical History: Are you Right Handed? ________ Left Handed? ________

If Injury, Describe How Occurred:

Is This a Liability Case: (Are you suing someone regarding this injury?) Yes ____ No ____

Current Medication/Vitamin Use: ________ None

Drug/Vitamin Name	Dosage	How Many Times Per Day

Childhood Illnesses: (Unusual illnesses such as rheumatic fever, polio, heart murmur, etc.) ______________________

Past Medical History: (Check all that apply)

____ None ____ Hypertension ____ Diabetes ____ Stroke ____ Anemia ____ Neurologic Disease

____ Renal Disease ____ Liver Disease ____ Gout ____ Cancer (type: ______________________)

____ Cardiac Disease ____ Pulmonary Disease ____ Ulcers (type: ______________________)

____ Other ____

Allergies: ______ None Known Iodine/Betadine ____________ Adhesive Tape ____________

Drugs (List name and type of reaction) ____

Alcohol Usage: ____ None ____ Infrequent ____ Occasional ____ Moderate ____ Heavy

Smoking: ______ Yes # of Packs per Day ________ ____ # Years Smoking ____ Not Now, Quit ______ Years Ago

Smoked ________ packs per Day for ______ Years ________ Never Smoked

Past Surgical History: (All types) ________ None

Type	Date	Doctor

Family History: (Please list age, general health, previous illnesses, deceased or living)

Mother ______________________ Father ______________________

Brother(s) ______________________ Sister(s) ______________________

Other Information Pertinent to Your Care: ______________________

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I give my permission to South Florida Hand and Orthopaedic Center to administer medical treatment including x-rays to my son/daughter (Must be signed by parent/guardian if child is under 18 years of age).

Signed ______________________

Patient's or Authorized Person's Signature. ____________
I authorize the release of any medical or other information necessary to process an insurance claim.

Authorized of Payment to Physician:
I authorize payment of medical benefits to SFHOC.

A Special Message for our Patients

To Our Patient:

Add

Our doctors accept Medicare assignment and we bill Medicare electronically for you. We will file your secondary insurance for you. In most cases, the secondary forwards payment directly to us, in the event that they send the check to you directly, we do require that your forward these funds immediately.

PPO, HMO and Commercial Insurance Patients:

If we are participating provider, we will bill your plan, but you are responsible to pay your co-pay and/or deductible at the time of service. If a referral is required, you are required to obtain this referral and inform us before each visit that you have this referral.

If the above policy poses any problem for you, please feel free to discuss this with our front desk personnel.

I have read the above credit policy of South Florida Hand and Orthopaedic center and agree to this by signing below.

Signature ______________________ Date ______________