South Florida Hand and Orthopaedic Center

Date _____

Patient Last Name _____ First Name _____ Initial ____
Local Address _____
(Street) (Apt#) (City) (State) (Zip)
Permanent Address _____
Home Phone ( ) _____ Work Phone ( ) _____ Cell ( ) _____
Date of Birth _____ Age ___ Sex ___ SS#: _____ M D S W Spouses Name _____
Employer Name/Address _____
Spouse's Name/Address _____
Email Address _____

Referred By _____ Family Physician (P.C.P.) _____

*Have you seen another orthopaedic for treatment within the last 3 years? _____
Date Illness/Injury Began _____ Is this related to your employment? Yes _____ No _____
If injury, type: Auto _____ At Work _____ Other Accident _____
Describe Symptoms _____
If injury, describe how it occurred? _____
_____
Is this a liability case? Yes _____ No _____

Primary Insurance _____ ID# _____
Primary Policy Holder's Name _____ Date of Birth _____
Secondary Insurance _____ ID# _____
Primary Policy Holder's Name _____ Date of Birth _____

I give 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 the 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.
x _____

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

Please print legibly and sign the next 2 pages entirely before returning to receptionist.

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

PPO, HMO, and Commercial Insurance Patients:
If we are a participating provider, we will bill your plan, but you **YOU ARE RESPONSIBLE** to pay your co-pay and/or deductible. If a referral is required, **YOU THE PATIENT** are required to obtain this referral and inform us before each visit that you have this referral.

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

Signature _____ Date _____

South Florida Hand – Medical History

Name: _____ Date: _____

Age: _____ Sex: M / F Height: _____ Weight: _____ Blood Pressure: _____

Dominant Hand: Are you right-handed, left-handed, or ambidextrous (both-handed)?

Medical History: Do you have now or have you ever been treated for? **Please circle Y or N.**

Y / N Diabetes
Y / N Thyroid Problems
Y / N Circulatory / Vascular Problems
Y / N Stroke
Y / N Heart Problems: _____
Y / N GI Problems: _____
Y / N Respiratory/Lung Problems: _____
Y / N Arthritis
Y / N Liver Problems: Cirrhosis, Hepatitis
Y / N Kidney Stones or Problems
Y/ N Anxiety / Depression / Bipolar
Y / N Anemia or Bleeding Disorder
Y / N Cancer: Type _____

Y / N Hypoglycemia
Y / N High Cholesterol
Y / N Hypertension/High Blood Pressure
Y / N Seizure Disorder
Y / N HIV
Y / N Skin Problems
Y / N Eye Problems: Cataracts, Glaucoma
Y / N Sinus Problems

Other illnesses, medical problems, or major injuries, past or present: _____
_____

Allergies to Medications/Latex/Adhesives? _____
What is the reaction? _____

Current Pharmacy name, address, and phone number? _____
_____

Current Medications: _____
_____

List all previous surgeries: _____
_____

Do you smoke? (Please check one) Former_____ Current _____ Never _____
Do you drink alcohol? Y / N
Drug Use? Y / N
Are you or could you be pregnant? Y / N

Family Medical History: **Please circle Y or N.**

Y/ N Diabetes
Y / N Heart Problems
Y / N Stroke
Y / N Asthma
Y / N Thyroid Problems
Y / N Hypertension
Y / N Cancer – Type: _____
Y / N Arthritis

Patient Signature: _____ Date: _____

Email Address: _____

South Florida Hand and Orthopaedic Center

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of any protected health information by South Florida Hand & Orthopaedic Center for the purpose of diagnosing or providing treatment to me and obtaining payment for my healthcare bills or to conduct health care operations of South Florida Hand & Orthopaedic Center. I understand that diagnosis or treatment of me by South Florida Hand & Orthopaedic Center may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is being used or disclosed to carry out treatment, payment or health care operations of the practice. South Florida Hand & Orthopaedic Center is not required to agree to the restrictions that I may request. However, if South Florida Hand & Orthopaedic Center agrees to a restriction that I request, the restriction is binding on South Florida Hand & Orthopaedic Center.

I have a right to revoke this consent in writing, at any time, except to the extent that South Florida Hand & Orthopaedic Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and collect or received by my 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 or condition and identifies me, or there is a reasonable basis to believe that this information may identify me.

I understand that I have the right to review South Florida Hand & Orthopaedic Center's Notice of Privacy Practices prior to signing this document. The South Florida Hand & Orthopaedic Center's Notice of Privacy Practices has been provided to me. 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 South Florida Hand & Orthopaedic Center. The Notice of Privacy Practices also describes my rights and the South Florida Hand & Orthopaedic Center's duties with respect to my protected health information.

South Florida Hand & Orthopaedic Center reserves the right to change the privacy practice that are described in the Notice of Privacy Practices. I may obtain a revised notice by calling the office and requesting a copy be sent in the mail or asking for one at the time of my next appointment.

X-rays taken in this office are a permanent part of your medical record and are therefore the sole property of South Florida Hand & Orthopaedic Center. If you require x-rays for any reason, we will be happy to copy the films for a fee. We are obligated by law to make this policy mandatory, therefore, no exceptions can be made.

X _____ _____

Signature of Patient Date

X _____

Name of Patient (PRINT)

X _____

Description of Personal Representative's Authority