Once Forms are complete, please send to forms@citrusortho.net or send via a portal message or fax to 352-746-6907 for expedited service or bring to appt.

CITRUS ORTHOPAEDIC AND JOINT INSTITUTE PATIENT INFO. SHEET

DATE:_____ TIME: _____ DR: _____

PATIENT INFO:

PRIMARY CARE DOCTOR:_____ **REFERRING:** _____

NAME: _____ **SEX**: _____
First Middle Last

AGE: _____ **DOB**:_____ **SS#** _____

RACE:_____ ***ETHNICITY:*** ◯ ***Hispanic*** ◯ ***Non Hispanic*** ◯ ***Refused***

PREFERRED LANG_____ ***MARITAL STATUS:*** _____

ADDRESS: _____

PHONE: _____(H)_____(M) _____ (W)

EMAIL: _____

EMERGENCY CONTACT:_____ **PHONE:**_____

EMPLOYED STATUS: ◯ Employed ◯ Unemployed ◯ Retired ◯ Disabled

EMPLOYER: _____

GUARANTOR INFO : (Person Responsible for Bill)

GUARANTOR:_____ **GUARANTOR SS NO**: _____

SEX: _____ **GUARANTOR PHONE #:**_____(H)_____(M) _____(W)

GUARANTOR ADDRESS: _____

PREFERRED PHARMACY: _____
Name Phone No.

INSURANCE:
PRIMARY: _____ **SUBSCRIBER**: _____

SUBSCRIBER DOB: _____ **POLICY or ID #:** _____

GROUP #:_____

SECONDARY:_____ **SUBSCRIBER**: _____

SUBSCRIBER DOB: _____ **POLICY or ID#** _____

GRP #: _____

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by my insurance.

Patient Signature_____ DATE:_____

Patient Name Printed _____

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MEDICAL HISTORY FORM

NAME: _____ AGE:_____
First Middle Last

Primary Insurance:_____

HEIGHT:_____WEIGHT:_____

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS:

Please put a check {x) next to any illness or problem that applies to you.

☐ Heart Attack	☐ GI/Bleed Peptic Ulcer	☐ Diabetes ☐ Type I ☐ Type II
☐ Heart Trouble/A Fib	☐ Bowel/Bladder Dysfunction	☐ Weight Loss
☐ High Blood Pressure	☐ Congestive Heart Failure	☐ Fever
☐ Stroke	☐ Bleeding Disorders	☐ Glaucoma
☐ Asthma	☐ Sickle Cell	☐ Hypothyroidism
☐ COPD/Lung Disease	☐ Blood Clots	☐ Osteoarthritis
☐ Pneumonia	☐ Anemia	☐ Rheumatoid Arthritis
☐ Cough	☐ Birth Defects	☐ Fibromyalgia
☐ HIV	☐ Seizures	☐ Gout
☐ Parkinson's Disease	☐ Kidney Disease	☐ Depression
☐ Hepatitis/Liver Disease	☐ Cancer (type)_____	☐ Other_____

PAST SURGERIES: Please list	

ALLERGY	REACTION

PRESCRIPTIONS- Please include over the counter drugs or vitamins					
NAME	FREQUENCY	DOSE	NAME	FREQUENCY	DOSE

Are you taking any over the counter blood thinners? ie baby aspirin _____

Once Forms are complete, please send to forms@citrusortho.net or send via a portal message or fax to 352-746-6907 for expedited service or bring to appt.

MEDICAL HISTORY FORM page 2

SOCIAL HISTORY:
Are you? ◯ Single ◯ Married ◯ Divorced ◯ Widowed
Work Status: ◯ Unemployed ◯ Disabled ◯ Retired ◯ Student
☐ Employed- Occupation_____
Employer _____
Current Cigarette Smoker? ◯ Yes ◯ No If Yes:_____Packs per Day
Former Cigarette Smoker? ◯ Yes ◯ No If Yes: _____Number of Yrs.
Other Tobacco Use:_____
Alcohol Use ☐ Beer/Wine,___times a wk.; ☐ Shots/Liquor,____times a wk
Other Drug Use:_____
Who Lives in your house that can care for you?_____

FAMILY HISTORY:

Please put a check (x) next to any illness or problem that applies to family members:

☐ Arthritis ☐ Heart Disease ☐ Rheumatoid Arthritis
☐ Gout ☐ Diabetes ☐ Bleeding Disorder
☐ Anesthesia Trouble ☐ Sickle Cell Anemia ☐ Cancer:_____
☐ Other_____

HEALTH SCREENING QUESTIONS:
How long ago was your most recent mammogram? ___Years ___Months ☐ N/A
How long ago was your most recent PAP smear? ___ Years ___Months ☐ N/A
How long ago was your most recent colonoscopy? ___ Years ___Months ☐ N/A
Have you had a FLU shot this season? ◯ Yes ◯ No If Yes, Date/Month _____
Have you ever had an immunization for pneumonia? ◯ Yes ◯ No If Yes, Date/Month ___
Have you fallen in the last year? ◯ Yes ◯ No (if yes, answer one of the next two questions)
I have fallen ONCE in the last year? ◯ Yes ◯ No
I have fallen MORE than once in the last year? ◯ Yes ◯ No

Name of primary/family doctor? _____ Last date seen? _____ or NA ☐
Do you have a pain management doctor? ◯ Yes ◯ No If yes, who?

Patient Signature:_____ DATE:_____

Patient Name Printed:_____

For Official only--------Dr. Review ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

CONDITIONS OF TREATMENT BY COJI

LIFETIME AUTHORIZATION INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I. PERMISSION FOR TREATMENT - Permission is hereby granted for physicians, physician assistants and employees or agents of Citrus Orthopaedic and Joint Institute to render to the below named patient such medical and surgical treatment as deemed necessary.

II. RELEASE OF INFORMATION - I, the below named patient, do hereby authorize any physician examining and/or treating me to release any medical condition and records concerning diagnosis and treatment when requested to:

a. such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

b. any referring physician to ensure continuity of medical care

c. other treating providers within the Corporation

III. PHYSICIAN INSURANCE ASSIGNMENT - By signing in the space below as Patient and/or subscriber, I hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charges for these services.

III. MEDICARE/MEDICAID - I, the undersigned, certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carriers any information needed for this of a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

IV. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

I understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance (AFTER THE REQUIRED CONTRACTUAL PROVIDER ADJUSTMENTS) not paid for by my insurance or third payor within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. If this account is assigned to a collection agency, the collection fees of 33% of total balance will be passed on and payable by patient
Initials:_____

Patient
Signature_____Date_____

Patient Name Printed _____

Subscriber Signature (if different from patient)_____

Subscriber Name Printed _____

ORIGINAL SIGNATURE ON FILE AT PHYSICIAN'S OFFICE

CITRUS ORTHOPAEDIC AND JOINT INSTITUTE
NARCOTIC AGREEMENT

In the event that you are prescribed narcotic pain medications by one of our physicians, he will discuss the risk and benefits, risks of abuse, addiction and physical dependency of that medication. You will have certain responsibilities which will be in effect when you are taking these medications. This agreement will remain in effect for the lifetime of treatment at our facility.

1. You agree not to increase the dosage or how often you take the medication without getting prior approval from your physician.

   Initial_____

2. No other physician may offer you any controlled substance (potentially addicting or sedating medication) at the same time you are receiving a controlled substance from me. If this is Offered by another doctor, you are obligated to inform me and the other physician of the drugs you currently take.

   Initial_____

3. There will be no early refills. If medications are stolen, you must complete a police report, provide us with a copy and schedule an office visit to discuss receiving an early refill with your physician.

   Initial_____

4. If you show signs or symptoms of substance abuse you will be immediately referred to pain management, an addiction medicine specialist or a mental health addiction facility.

   Initial_____

5. If you violate this agreement, your care will be terminated.

   Initial_____

Signature _____ Date_____

Patient Name Printed_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
CITRUS ORTHOPAEDIC AND JOINT INSTITUTE, PA

As required by the Privacy Regulations, I hereby acknowledge that I have been provided with a copy of **CITRUS ORTHOPAEDIC AND JOINT INSTITUTE, PA's** "Notice of Privacy Practices".

As required by the Privacy Regulations, **CITRUS ORTHOPAEDIC AND JOINT INSTITUTE, PA** has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that **CITRUS ORTHOPAEDIC AND JOINT INSTITUTE, PA** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Patient Signature: _____ (guardian if under 18) Date: _____

Patient Name Printed: _____

(OFFICE USE ONLY)

Signed form received by: _____Date: _____

Good Faith effort to obtain receipt: (Describe) _____
_____