

# 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 \_\_\_\_\_

### 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.

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

## MEDICAL HISTORY FORM page 2

<b>SOCIAL HISTORY:</b>
Are you? <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Work Status: <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Student
<input type="checkbox"/> Employed- Occupation _____
Employer _____
Current Cigarette Smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: _____ Packs per Day
Former Cigarette Smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: _____ Number of Yrs.
Other Tobacco Use: _____
Alcohol Use <input type="checkbox"/> Beer/Wine, _____ times a wk.; <input type="checkbox"/> 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:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Gout               | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Bleeding Disorder    |
| <input type="checkbox"/> Anesthesia Trouble | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Cancer: _____        |
| <input type="checkbox"/> Other _____        |   |   |

### HEALTH SCREENING QUESTIONS:

How long ago was your most recent mammogram? <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> N/A
How long ago was your most recent PAP smear? <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> N/A
How long ago was your most recent colonoscopy? <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> N/A
Have you had a FLU shot this season? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date/Month _____
Have you ever had an immunization for pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date/Month _____
Have you fallen in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, answer one of the next two questions)
I have fallen ONCE in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No
I have fallen MORE than once in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No

Name of primary/family doctor? _____ Last date seen? _____ or NA _____
Do you have a pain management doctor? <input type="checkbox"/> Yes <input type="checkbox"/> 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: \_\_\_\_\_

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### **(OFFICE USE ONLY)**

Signed form received by: \_\_\_\_\_ Date: \_\_\_\_\_

Good Faith effort to obtain receipt: (Describe) \_\_\_\_\_

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