ORTHOONE
JACKSONVILLE
EXCELLENCE IN ORTHOPEDIC CARE

Todays Date:_____

Patient's Name:_____

Address:_____

City:_____State:_____ ZipCode:_____

DOB:_____ SSN:_____

Sex: Male___ Female___ *Marital Status:* Single___ Married___ Divorced___ Widow___

Home Phone:_____ Cell Phone: _____

Email:_____

IN CASE OF EMERGENCY

Name:_____ Relationship to Patient: _____

Home Phone:_____ Cell Phone:_____Work Phone:_____

INJURY INFORMATION

Type of Injury: Auto____Slip and Fall_____ Work____ Other_____ **Date of Accident:**_____

If Auto: Driver____ Passenger____

HEALTH INSURANCE INFORMATION

Subscriber Name: _____Date of Birth:_____

Relationship to Subscriber:_____

Primary Insurance:_____

Group #:_____Policy #:_____

PATIENT/GUARDIAN SIGNATURE:_____**DATE:**_____

I authorize the release of medical information necessary to process this and related insurance claims. I authorize the payment of insurance benefits to be made to: ORTHO ONE JACKSONVILLE. To whom the assignment has been made.

Kennerly 6100 Kennerly Road, Suite# 202, Jacksonville, FL 32216

Riverside 1045 Riverside Avenue, Suite# 100, Jacksonville, FL 32204

Phone: (904) 619-3048 Fax: (904) 619-6168

PATIENT MEDICAL HISTORY

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

Date of Birth: _____ **Age:** _____ **Height:**_____ **Weight:**_____

Sex :_____ **Race:**_____ **Ethnicity:**_____ **Preferred Language:**_____

Home Phone:_____ **Work Phone:**_____ **Cellular Phone:**_____

Pharmacy:_____ **Pharmacy address & phone:**_____

CHIEF COMPLAINT

**Why are you here today? _____

_____

_____

**What Happened? _____

_____

_____

_____

Are you Right or Left Handed? _____ Date of Injury or Onset of Symptoms? _____

Is this injury due to one or more of the following: (please circle) ☐ Auto related ☐ Work related ☐ Slip and Fall

Other (please explain)_____

Were you seen in the E.R./or by another physician? _____

Are your symptoms improving/unchanged/or worsening?_____

Are you working now? _____ What is your Occupation? _____

HISTORY OF PRESENT ILLNESS

Initial symptoms:

☐ Catching ☐ Locking ☐ Weakness ☐ Numbness

☐ Initial popping sound ☐ Slipping ☐ Pain with overhead activity ☐ Tingling

☐ Giving way ☐ Stiffness ☐ Pain with reaching behind neck/back

☐ Weight bearing: ☐ with pain ☐ with no pain ☐ unable to bear weight ☐ Night Pain

Pain : ***PLEASE ANSWER THE FOLLOWING TO HELP YOU DESCRIBE YOUR PAIN***

Quality - ☐ *Aching* ☐ *Burning* ☐ *Diffuse* ☐ *Dull* ☐ *Knifelike* ☐ *Pounding*

☐ *Sharp* ☐ *Stabbing* ☐ *Tearing* ☐ *Throbbing*

Frequency of your Pain: Intermittent_____ Constant_____ Frequent_____ Infrequent_____

Severity of your pain **at this time**:(Mild--1--2--3) (Moderate--4--5--6--7) (Intense--8--9-10) (Rate pain on a scale from 1 to 10)

Severity of your pain **at its worse**:(Mild--1--2--3) (Moderate--4--5--6--7) (Intense--8--9-10) (Rate pain on a scale from 1 to 10)

Activity Limitations: Please *check* any of the following limitations that apply or write your own personal limitation.

☐ Climbing stairs ☐ In and out of chair ☐ Walking ☐ Lifting

☐ In and out of car ☐ Kneeling ☐ Bending forward ☐ Household chores

☐ Working light duty ☐ Unable to work ☐ Yard work ☐ Getting dressed

My personal limitations: _____

What makes symptoms worse?_____

What makes symptoms better?_____

Therapies tried:

☐ Braces ☐ Crutches ☐ Cold/Heat ☐ Elevation ☐ Physical Therapy ☐ Chiropractor

Medication:

☐ Anti-inflammatory ☐ Narcotics ☐ Steroids ☐ Over-the-counter ☐ Injections

Any previous medical or surgical treatment for this condition? ◯ Yes ◯ No If yes, what:_____

_____

PAST MEDICAL HISTORY

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

Please list your past illnesses

_____
_____
_____
_____
_____

Please list your past injuries.

_____
_____
_____
_____
_____

CURRENT MEDICATIONS

Medication Name	Dose	Why are you taking this medication?

ALLERGIES: (Please answer Y for yes or N/A if not applicable. **If yes,** please describe the adverse symptoms or reaction.
List medications you are allergic to:_____

_____

Environmental Allergies:_____
Food Allergies:_____
Cosmetic or personal care product Allergies:_____
Plastic Allergy:_____
Latex Allergy:_____

PAST SURGICAL HISTORY:

Surgical Procedure	Date	Name of Surgeon

CHILDHOOD DISEASES:
Asthma_____ Chicken Pox_____ Measles _____ Mumps_____ Rheumatic fever_____ Scarlet fever____

SOCIAL HISTORY:
Marital Status: _____Married _____Single _____Divorced _____Widowed _____Separated
Tobacco use - Current Smoker: Amount and duration _____Former Smoker ☐ Never Smoker ☐
Alcohol - Wine - Occasional_____ 2-3 times per week_____ Daily_____ Socially only_____
Mixed drinks or Hard Liquor - Occasional_____ 2-3 times per week_____ Daily_____ Socially only_____
Beer - Occasional_____ 2-3 times per week_____ Daily_____ Socially only_____
Ancillary aids - Glasses _____ Contacts _____ Dentures _____ Hearing aids _____
Drug use - Never used Drugs_____used Drugs in the past _____Using Drugs now Socially_____
Camping/Hunting - if yes, when & where _____
Scuba diving - if yes, state how often, how deep you dive and for how long: _____
Travel outside of the country, if so _____ where _____when

FAMILY HISTORY:
Father Status _____living ____ deceased
Illness_____
Cause of death_____; _____age at death

Mother Status _____living ____ deceased
Illness_____
Cause of death _____: _____age at death

REVIEW OF MEDICAL SYSTEMS

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

General/Constitutional:

Yes	No	
○	○	Decreased Activity
○	○	Change in appetite
○	○	Fever
○	○	Chills
○	○	Tires easily
○	○	Lost Weight
○	○	Gained Weight

Eyes:

Yes	No	
○	○	Recent vision changes
○	○	Double Vision

Ears Nose Throat:

○	○	Earaches
○	○	Hearing loss
○	○	Ear pain
○	○	Ear Ringing
○	○	Dizziness
○	○	Congestion
○	○	Nose Bleeds
○	○	Bleeding gums
○	○	Full Dentures
○	○	Partial Upper Dentures
○	○	Partial Lower Dentures
○	○	Difficulty swallowing
○	○	Hoarseness
○	○	Sore throat

Respiratory:

Yes	No	
○	○	Asthma
○	○	Bronchitis
○	○	Cough
○	○	Shortness of Breath
○	○	Bronchitis
○	○	Coughing up blood
○	○	Recent Respiratory Infection
○	○	Sleep Apnea

GI:

Yes	No	
○	○	Abdominal pain
○	○	Nausea
○	○	Vomiting
○	○	Diarrhea
○	○	Heartburn
○	○	Indigestion

Musculoskeletal:

Yes	No	
○	○	Joint pain
○	○	Tenderness
○	○	Weakness
○	○	Swelling
○	○	Redness
○	○	Stiffness
○	○	Cramping
○	○	Loss of motion

Neurological:

Yes	No	
○	○	Abnormality of walk
○	○	Balance
○	○	Blackouts
○	○	Burning sensations
○	○	Confusion
○	○	Coordination
○	○	Dizziness
○	○	Fainting
○	○	Headaches
○	○	Lightheadedness
○	○	Loss of consciousness
○	○	Loss of sensation
○	○	Memory loss
○	○	Numbness
○	○	Paralysis
○	○	Speech difficulty
○	○	Tingling
○	○	Tremor
○	○	Weakness

Skin:

Yes	No	
○	○	Lesions
○	○	Itching
○	○	Discoloration
○	○	Rash
○	○	Ulceration

Since the incident have you experienced any of the following questions.....

Psychiatric:

Yes	No	
○	○	Compulsive behavior
○	○	Mood swings

Hematologic/lymphatic:

Yes	No	
○	○	Easy bruising
○	○	Swollen lymph node
○	○	History of transfusion

GU:

Yes	No	
○	○	Pain with urination
○	○	Blood in Urine
○	○	Abnormal Urine test
○	○	Frequent urination
○	○	Kidney stones
○	○	Prostate surgery

Females

Yes	No	
○	○	Normal Menstruation
○	○	Menopause
○	○	Ovaries removed
○	○	Birth control pills

Cardiac:

Yes	No	
○	○	Chest pain
○	○	Heart murmur
○	○	Hypertension
○	○	Abnormal EKG
○	○	Cold hands & feet
○	○	Palpitations
○	○	Abnormal stress test
○	○	Edema

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PRIMARY CARE PHYSICIAN:

DOCTOR'S NAME: _____
FACILITY: _____
PHONE NUMBER: _____

NEUROLOGIST:

DOCTOR'S NAME: _____
FACILITY: _____
PHONE NUMBER: _____

CHIROPRACTIC DOCTOR:

DOCTOR'S NAME: _____
FACILITY: _____
PHONE NUMBER: _____
How Many Days/ Weeks/ Months of treatment? _____

Did the treatment help? _____ How Much Improvement? _____ [On a Scale 0% -100 %]

PAIN MANAGEMENT DOCTOR:

DOCTOR'S NAME: _____
FACILITY: _____
PHONE NUMBER: _____
How Many Days/ Weeks/ Months of treatment? _____
Did the treatment help? _____ How Much Improvement? _____ [On a Scale 0% -100 %]
What type of Injections/procedures have you received: (Please Circle below)

Epidural steroid injection	Selective nerve root block (SNRB)	Facet joint block
Facet Rhizotom	Sacroiliac Joint Block	Radiofrequency ablation

Other: _____

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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE & DEMAND

Insurer and Patient Please Read the following in its Entirely Carefully!

I, the undersigned patient/insured knowingly; voluntarily and intentionally assign the rights and benefits on my automobile insurance, A/K/A/ Personal Injury Protection (hereinafter PIP), Uninsured Motorist, and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered. I understand this document will allow the provider to file suit against an insurer for payment of the insurance benefits or an explanation of benefits and to seek §626.428 damages from insurer. If the provider's bills are applied to a deductible, I agree this will serve as a benefit to me. This assignment of benefits includes the cost of transportation, medications, supplies, and overdue interest and any potential claim for common law or statutory bad faith/ unfair claims handling. If the insurer disputes the validity of this assignment of benefits, the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to attest the validity of this document. The undersigned directs the insurer to pay the health care provider the maximum amount directly without any reductions & without including patients name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance including resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the names insured under said policy of insurance hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suite for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only, should the medical bills not exceed the premium refund, the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

Disputes: The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/ patient from liability unless there has been a prior written settlement agreed to by the health provider (Specifically the office manager) and the insurer as to the amount payable under the insurance policy. The insured and the provider hereby contest and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. If the PIP insurer states it can pay claims at 200% of Medicare then the insurer is instructed & directed to provide this provider with a copy of the policy of insurance within 10 days. Any effort by the insurer to pay a disputed debt as full satisfaction must be mailed to the address above, after speaking with the **Office Manager**, and mailed to the specific attention of the **Office Manager**. See Fla,Stat. §673.311.

EUO'S And IME'S If the insurer schedules a defense examination under oath (hereinafter "EUO") the insurer is hereby INSTRUCTED to send copy of said notification to provider. The provider or provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent or the insurer or the patient for any purpose. This assignment applies to both past and future medical expenses and is valid even undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance, exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to: endorse my name in any check for services rendered by the provider; and to request and obtain a copy of any statements or examinations under oath given by patient.

Release Of Information: I authorize this provider to: Furnish the insurer, insurer's intermediary, the patient's other medical providers, and the patient's attorney, via mail, fax, or E-mail, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & Policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOB's) for all providers and non-redacted PIP pay-out sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer, obtain copies of the entire claim file, the incident and property damage file, and all medical records, including but not limited to, documents, reports, scans, notes,

bills, opinions, x-rays, IME's, and MRI's, from any other medical provider or any insurer. The provider is not permitted to produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records from this provider private and confidential; the insurer is not authorized to provide these medical records to anyone without the patients and the provider's prior written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP pay-out sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this providers bill to the deductible. If the bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to; set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a court. Do not exhaust the policy. The insurer is instructed to inform, in writing the provider of any dispute.

Guarantee of payment: I understand and agree, I am personally responsible for all services received at ORTHO ONE JACKSONVILLE, and promise to pay regardless of my health insurance benefits and/or possible future payment from any judgement or verdict on my behalf I understand that if my account at ORTHO ONE JACKSONVILLE. is past 60 days overdue, it may be subject to 1.5% per month (18% year) finance charge. If the default amount is referred to a collection agency and/or for legal action, I agree to pay for reasonable court costs of collections.

Consent of Treatment: I give ORTHO ONE JACKSONVILLE. Permission to perform on myself (Or minor child who I declare I am the parent or legal guardian) such general procedures as they deem necessary in the diagnosis and/ or treatment of my (their) condition. My signature below verifies my full understanding of this consent and upon my request and possible risks regarding or assurance as to my results I may obtain from services received.

Certification: I certify that I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the providers prices for medical services, treatments and supplies are reasonable, usable and customary

ATTENTION: Please read, before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above terms..

Patient (Print)_____ DOB: _____

Signature: _____ *Date:* _____

Witness: _____ *Date:* _____