PLEASE PRINT CLEARLY **TODAY'S DATE:** _____

PATIENT'S NAME: (LAST) _____ **(FIRST)** _____ **(MI)**_____

SOCIAL SECURITY NUMBER: _____-_____-_____ EMAIL ADDRESS: _____@_____

I GIVE MY AUTHORIZATION FOR MY CHART TO BE WEB ENABLED (ONLINE/PORTAL ACCESS: ☐YES ☐NO

RACE: _____ ETHNICITY: _____ PREFERRED LANGUAGE: _____

ADDRESS: _____

CITY:_____ STATE:_____ ZIP: _____

MAILING ADDRESS (if different from above):_____

CITY:_____ STATE:_____ ZIP: _____

HOME PHONE:(____)_____-_____WORK PHONE:(_____)_____-_____CELL PHONE:(____)_____-_____

DATE OF BIRTH:_____ AGE:_____ MARITAL STATUS: ☐SINGLE ☐MARRIED SEX: ☐MALE ☐FEMALE

EMPLOYED BY: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS:_____CITY:_____STATE:_____ ZIP:_____

SPOUSE'S NAME: (LAST) _____(FIRST)_____(MI)_____

EMPLOYED BY: _____WORK PHONE: (__ _)_____-_____CELL PHONE: (____)_____-_____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the provider to release all information necessary to secure the payment of benefits.
I authorize the use of this signature on all insurance submissions.
I authorize the release of my medical records to my Referring and Primary Care Physician(s), if applicable.
Additionally, I authorize _____, (relationship to patient: _____), access to medical information pertaining to my treatment.

EMERGENCY CONTACT

NAME: (LAST) _____(FIRST)_____(MI)_____

RELATIONSHIP TO PATIENT: _____ CONTACT PHONE: ☐CELL ☐HOME ☐WORK NUMBER: (____)_____

COMPLETE THIS SECTION IF PATIENT IS A MINOR (under 18)

PERSON RESPONSIBLE FOR CHARGES (adult that accompanies minor at time of office visit):

NAME: (LAST) _____(FIRST)_____(MI)_____

RELATIONSHIP TO PATIENT: ☐MOTHER ☐FATHER ☐GRANDPARENT ☐OTHER: _____

SOCIAL SECURITY NUMBER: _____-_____-_____DATE OF BIRTH: _____ EMPLOYED BY: _____

ADDRESS (ONLY IF DIFFERENT FROM PATIENT): _____

HOME PHONE:(____)_____-_____WORK PHONE:(_____)_____-_____CELL PHONE:(____)_____-_____

PLEASE PRINT CLEARLY **TODAY'S DATE:** _____

PATIENT'S NAME: (LAST) _____ **(FIRST)** _____ **(MI)**_____

INSURANCE INFORMATION (this information can be found on your ID card)

PRIMARY INSURANCE NAME: _____CUSTOMER SERVICE PHONE NUMBER: (_____)_____

BILLING ADDRESS: _____CITY:_____STATE:_____ ZIP: _____

IDENTIFICATION #: _____ GROUP #: _____

POLICYHOLDER: ☐SELF ☐SPOUSE ☐FATHER ☐MOTHER ☐OTHER: _____

POLICYHOLDER'S NAME: _____ POLICYHOLDER'S DATE OF BIRTH: _____

SECONDARY INSURANCE NAME: _____ CUSTOMER SERVICE PHONE NUMBER: (_____)_____

BILLING ADDRESS: _____CITY:_____STATE:_____ ZIP: _____

IDENTIFICATION #: _____ GROUP #: _____

POLICYHOLDER: ☐SELF ☐SPOUSE ☐FATHER ☐MOTHER ☐OTHER: _____

POLICYHOLDER'S NAME: _____ POLICYHOLDER'S DATE OF BIRTH: _____

PRESCRIPTION/ RX CARD CARRIER: _____ PCN #:_____

BIN/ID#: _____ RX GROUP: _____

CONSENT FOR MEDICAL TREATMENT

I hereby authorize any treatment(s), agreed upon with the physicians, which may be deemed advisable.

OFFICE PRESCRIPTION POLICY

Our office requests a 48-72 hour notice to refill any medication(s) on weekdays. Medications requested on Friday after 1 pm, as well as Saturday and Sunday will not be refilled until Monday afternoon or Tuesday morning. It is our clinic policy that no medications will be refilled after office hours.

ASSIGNMENT AND AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND FINANCIAL RESPONSIBILITY

I hereby authorize payment directly to the provider for services, if any, otherwise payable to me for his/her services rendered.
I understand I am financially responsible for copay/co-insurance/deductible and non-covered services.
I understand I am financially responsible for all charges incurred whether or not paid by insurance.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. A $ 25.00 fee will be charged to your account for any returned checks.
I hereby irrevocably assign to "Jeffrey T. O'Brien, M.D., Inc.",d/b/a The Orthopedic Center, the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by "Jeffrey T. O'Brien, M.D., Inc.",d/b/a The Orthopedic Center.

NOTICE OF PRIVACY PRACTICES

I have received a copy of the HIPAA Notice of Privacy Practices for "Jeffrey T. O'Brien, M.D., Inc.".

I have read and completed this form and state the information is true to the best of my knowledge and belief. I have read and fully understand the above consent for medical treatment, office prescription policy, assignment and authorization to pay benefits to physician and financial responsibility, authorization to release information, and have received a copy of the HIPAA Notice of Privacy Practices for "Jeffrey T. O'Brien, M.D., Inc.".

Signature: _____ Date: _____

PLEASE PRINT CLEARLY **TODAY'S DATE:** _____

PATIENT'S NAME: (LAST) _____ **(FIRST)** _____ **(MI)**_____

MEDICAL HISTORY

REFERRED BY: ☐ PHYSICIAN ☐ EMERGENCY ROOM ☐ YELLOW PAGES ☐ NEWSPAPER ☐ SEMINAR ☐ AD ☐ FRIEND

☐ INSURANCE ☐ ATTORNEY ☐ OTHER: _____

_____(_____)_____

LAST NAME FIRST NAME PHONE NUMBER

PRIMARY CARE PHYSICIAN (IF ANY):

_____(_____)_____

LAST NAME FIRST NAME PHONE NUMBER

REASON FOR VISIT TODAY: _____

_____

CURRENT PROBLEM IS THE RESULT OF A: (PLEASE CHECK THE APPROPRIATE BLOCK)

☐ CAR ACCIDENT ☐ WORK ACCIDENT ☐ ACCIDENT OTHER: _____ ☐ NOT ACCIDENT RELATED

DATE OF ACCIDENT: _____ ACCIDENT LOCATION: _____ STATE: _____

DESCRIBE HOW YOUR INJURY OCCURRED: _____

_____

TO WHOM HAVE YOU MADE A REPORT OF YOUR ACCIDENT? ☐ AUTO INSURANCE ☐ EMPLOYER ☐ WORKER'S COMP.

☐ OTHER_____

ATTORNEY NAME AND PHONE NUMBER (IF APPLICABLE): _____

CURRENT MEDICATION ☐ NO MEDICATIONS USED

	DOSAGE	FREQUENCY	REASON FOR TAKING MEDICATION
1.			
2.			
3.			
4.			
5.			
6.			
7.			

PHARMACY

NAME:_____ LOCATION:_____PHONE_____

ALLERGIES ☐ NONE KNOWN

PAST MEDICAL HISTORY (Please check all that apply)

☐ ANEMIA
☐ ANGINA
☐ ANXIETY
☐ ARTHRITIS
☐ ASTHMA
☐ BLEEDING DISORDER
☐ BLOOD CLOT
☐ CANCER
☐ CHRONIC BACK PAIN
☐ CLAUSTROPHOBIC
☐ CONGESTIVE HEART FAILURE
☐ DEPRESSION
☐ DIABETES
☐ DIABETIC FOOT ULCER
☐ DIALYSIS
☐ EMPHYSEMA
☐ GI BLEED
☐ GOUT
☐ HEART ATTACK
☐ HEPATITIS
☐ HIGH BLOOD PRESSURE
☐ HIV
☐ HYPERTHYROIDISM
☐ HYPOTHYROIDISM
☐ IRREGULAR HEARTBEAT
☐ KIDNEY FAILURE
☐ LIVER PROBLEMS
☐ LUPUS
☐ NEUROLOGICAL DISORDER
☐ PINCHED NERVE
☐ POOR CIRCULATION
☐ PROSTATE PROBLEMS
☐ PULMONARY EMBOLISM
☐ REFLUX
☐ RHEUMATOID ARTHRITIS
☐ SEIZURES
☐ SLEEP APNEA
☐ STOMACH ULCERS
☐ STROKE
☐ TUMORS/GROWTHS
☐ NONE (NEGATIVE)
☐ OTHER _____
☐ PAIN MANAGEMENT
PM PHYSICIAN NAME: _____

PLEASE ADDRESS ANY OTHER MEDICAL HISTORY CONCERNS WITH YOUR PROVIDER

Continue on Page 4 with Past Surgical History Problems

PLEASE PRINT CLEARLY **TODAY'S DATE:** _____

PATIENT'S NAME: (LAST) _____ **(FIRST)** _____ **(MI)**_____

PAST SURGICAL HISTORY (Please check all that apply)

- ☐ AMPUTATION
- ☐ AORTIC VALVE REPLACEMENT
- ☐ APPENDECTOMY
- ☐ BACK SURGERY
- ☐ BREAST SURGERY
- ☐ CABG (CARDIAC BYPASS)
- ☐ CAROTID ENDARTERECTOMY
- ☐ CARPAL TUNNEL
- ☐ CHOLECYSTECTOMY (REMOVAL GALLBLADDER)
- ☐ COLON RESECTION
- ☐ GASTRIC BYPASS
- ☐ HIP REPLACEMENT
- ☐ HYSTERECTOMY
- ☐ KNEE ARTHROSCOPY
- ☐ KNEE REPLACEMENT
- ☐ KYPHOPLASTY
- ☐ MITRAL VALVE REPLACEMENT
- ☐ NEPHRECTOMY (REMOVAL KIDNEY)
- ☐ PACEMAKER
- ☐ PNEUMONECTOMY (REMOVAL LUNG)
- ☐ ROTATOR CUFF REPAIR
- ☐ TONSILLECTOMY
- ☐ VERTEBROPLASTY
- ☐ ANESTHESIA PROBLEM
- ☐ SURGICAL COMPLICATION
- ☐ NONE (NEGATIVE)
- ☐ OTHER:_____

FAMILY HISTORY (Please check all that apply)

Do any of your relatives have (or did they have) problems with any of the following? Please check all that applies and list relationship for example: F (Father), M (Mother), PGF (Paternal Grandfather), MGM (Maternal Grandmother), S (Sibling)

- ☐ ANESTHESIA PROBLEMS_____
- ☐ BLEEDING DISORDER_____
- ☐ CANCER_____
- ☐ DIABETES_____
- ☐ HEART ATTACK_____
- ☐ OSTEOPOROSIS_____
- ☐ RHEUMATOID ARTHRITIS_____
- ☐ UNREMARKABLE/UNKNOWN

SOCIAL HISTORY (Please check all that apply)

RISK FACTORS:

SMOKING: ☐ YES (PACKS/DAY):_____ ☐ NO ☐ FORMER YEAR QUIT:_____

ALCOHOL USE: ☐ YES (TYPE/AMOUNT/DAY):_____ ☐ NO

TYPE OF WORK:

☐ PHYSICAL WORK ☐ SEDENTARY WORK ☐ OUT OF WORK ☐ RETIRED ☐ DISABLED ☐ HOMEMAKER

☐ OTHER:_____ ☐ STUDENT ☐ REGULAR DUTY ☐ LIGHT DUTY: RESTRICTIONS:_____

REVIEW OF SYSTEMS (Please check all that apply)

GENERAL	☐ FEVER/CHILLS	☐ FATIGUE	☐ SLEEP PROBLEMS		
EYES	☐ BLURRY VISION	☐ DOUBLE VISION			
EAR-NOSE-THROAT	☐ DECREASED HEARING	☐ SORE THROAT	☐ EARS RINGING		
CARDIOVASCULAR	☐ CHEST PAIN	☐ FAINTING			
RESPIRATORY	☐ SHORTNESS OF BREATH	☐ COUGH			
GASTROINTESTINAL	☐ HEARTBURN	☐ CONSTIPATION	☐ NAUSEA	☐ VOMITING	☐ DIARRHEA
GENITOURINARY	☐ PAIN ON URINATION	☐ INCONTINENCE	☐ INCREASED FREQUENCY		
MUSCULOSKELETAL	☐ JOINT SWELLING	☐ CRAMPS	☐ WEAKNESS		
SKIN	☐ RASH	☐ ITCHING			
NEUROLOGIC	☐ NUMBNESS	☐ TINGLING	☐ LOSS OF BALANCE		
PSYCHIATRIC	☐ ANXIETY	☐ DEPRESSION			
ENDOCRINE	☐ WEIGHT CHANGE	☐ THIRSTY ALL THE TIME			
HEMATOLOGIC	☐ BRUISING	☐ BLEEDING	☐ ENLARGED LYMPH NODES		

OTHER: _____

PATIENT SIGNATURE: _____ DATE: _____

Physician Use Only:

VITAL SIGNS **Pain Scale:** _____/10 **Fall Risk Assessment**: None 1 2+

HEIGHT: _____INCHES **WEIGHT:** _____POUNDS **BP:** _____/_____ **PULSE**:_____

THE ORTHOPEDIC CENTER
650 S. COURTENAY PARKWAY, SUITE 200, MERRITT ISLAND, FL 32952, phone: (321) 394-2660, fax (321) 394-2669
1421 MALABAR ROAD, SUITE 200, PALM BAY, FL 32907, phone: (321) 308-2660, fax (321) 984-9303