TAMPA BAY ORTHOPAEDICS

PATIENT INFORMATION PLEASE PRINT AND COMPLETE ALL SECTIONS, USE BLACK INK ONLY

DATE: _____

PATIENT NAME: _____ BIRTH DATE: _____

ADDRESS: _____ CITY:_____STATE:_____Zip: _____

PATIENT SSN # : _____ EMAIL: _____

CELL PHONE #: _____ HOME #: _____ WORK # _____

For Tricare patients, only, please provide the following for billing purposes:
(skip if same as above)
SSN FOR SPONSOR: _____ SPONSOR'S DOB: _____

PRIMARY CARE DOCTOR _____**I DON'T HAVE ONE**

NAME: _____ PHONE #: _____ FAX#: _____

REFERRING PHYSICIAN OR FRIEND: _____

REFERRING PHYSICIANS PHONE #: _____ NO ONE REFERRED ME____

PHARMACY (REQUIRED)

NAME: _____ _____ PHONE #: _____

STREET: _____ (INTERSECTS WITH WHAT STREET) _____

CITY: _____

IF YOU WANT A FAMILY MEMBER TO HAVE ACCESS TO SPEAK TO OUR STAFF ABOUT YOUR HEALTH CARE PLEASE INDICATE THAT PERSON'S NAME, RELATIONSHIP AND PHONE # HERE:

NAME: _____ RELATIONSHIP: _____

PHONE #: _____

NAME: _____ RELATIONSHIP: _____

PHONE #: _____

NEW PROBLEM QUESTIONAIRE

PATIENT NAME: _____ DATE: _____

REASON FOR VISIT & HOW IT HAPPENED (INDICATE INVOLVED SIDE): _____

_____

_____

_____

INVOVLED BODY PART: [ ] SHOULDER[ ] ELBOW [ ] HUMERUS [ ] FOREARM [ ] WRIST [ ] HAND

[ ]HIP [ ]FEMUR [ ] KNEE [ ] TIBIA/FIBULA [ ]ANKLE [ ] FOOT [ ] OTHER:_____

INVOVLED SIDE: [ ] RIGHT [ ] LEFT [ ]BOTH

INJURY OR PAIN RELATED TO: (CIRCLE ONE THAT APPLIES)

WORK **AUTO ACCIDENT** **SCHOOL** **SPORTS** **OTHER**

DATE OF INJURY: _____ IF NOT AN INJURY, DATE OF ONSET PAIN: _____

CHECK ALL BOXES THAT APPLY. Indicate which body part for more than one injury/problem

SEVERITY: [ ] MILD [ ] MODERATE [ ] SEVERE [ ] VARIABLE: (EXPLAIN) _____

[ ] PAIN [ ]STIFFNESS [ ] SWELLING [ ] NUMBNESS [ ] TINGLING

IT FEELS:

[ ] SHARP [ ]THROBBING [ ] TINGLING [ ]CRAMPING [ ]DEEP [ ]DULL

[] ACHING [ ] BURNING [ ] SUPERFICIAL [ ] OTHER:_____

WHAT IS YOUR LEVEL OF PAIN ON A SCALE OF 0-10? WITH 0 BEING NO PAIN AND 10 BEING THE WORST PAIN.

_____

0 1 2 3 4 5 6 7 8 9 10

SYMPTOMS OCCUR: (CHECK ALL THAT APPLY)

[ ] WITH ACTIVITY [ ] AFTER ACTIVITY [ ]IN THE MORNING [ ]EVENING [ ] AT NIGHT [ ]CONSTANTLY

WHAT MAKES THE PAIN WORSE? _____

[ ] NOTHING MAKES THE PAIN WORSE.

DOES ANYTHING MAKE IT BETTER? _____

[ ] NOTHING MAKES THE PAIN BETTER.

TREATMENT YOU HAVE HAD FOR THIS PROBLEM:

[ ] NONE [ ] REST [ ] ICE [ ] HEAT [ ] MEDICATION [ ] THERAPY [ ]SPLINT [ ] CAST

PREVIOUS STUDIES YOU'VE HAD FOR THIS PROBLEM:(ONLY FOR TODAYS INJURY/PROBLEM)

[ ] NONE [ ] X-RAY [ ]MRI [ ]CT SCAN [ ]NERVE STUDIES DATE :_____

DO YOU HAVE AN ATTORNEY FOR THIS INJURY? [ ] YES [ ] NO IF YES, PROVIDE INFORMATION

ATTORNEY'S NAME: _____ PHONE#_____

DOMINANT HAND: [ ] RIGHT [ ] LEFT

DEMOGRAPHIC'S: (CIRCLE ALL THAT APPLY)

RACE: WHITE/BLACK/HISPANIC/ASIAN/AMERICAN INDIAN/OTHER: _____
DECLINE [ ]
ETHNICITY: AMERICAN/ENGLISH/HISPANIC OR LATIN/INDIAN/HINDU/OTHER: _____
DECLINE [ ]

PREFERRED LANGUAGE: ENGLISH/ SPANISH/OTHER:_____

HEIGHT:_____ WEIGHT:_____ SEX:_____

Name:_____

Date:_____

PAST MEDICAL HISTORY

[ ]Stroke [ ]Heart Trouble [ ]High Blood Pressure [ ]Diabetes [ ]Arthritis [ ]Gout [ ]Seizures
[ ]Mental Illness [ ]Kidney Trouble [ ]Cancer Type:_____ [ ]Bleeding Disorders [ ]Anemia
[ ]Alcoholism [ ]Lung Disease [ ]Tuberculosis [ ]Phlebitis [ ]Stomach Ulcers [ ]Liver Trouble
[ ]Thyroid Trouble [ ]Aids/HIV [ ]Osteoporosis [ ]NONE [ ]Other: _____

List of Surgeries and Dates:[ ] NONE

_____

_____

Current Medications [ ]**None** [ ]Dietary Supplements

_____

_____

Drug Allergies **[ ]No Known Drug Allergies [ ]Latex Allergy**

_____

_____

FAMILY MEDICAL HISTORY

(Mother, Father, Siblings, Grandparents)

[ ]Stroke [ ]Heart Trouble [ ]High Blood Pressure [ ]Diabetes [ ]Arthritis [ ]Gout [ ]Seizures
[ ]Mental Illness [ ]Kidney Trouble/Stones [ ] Cancer [ ]Bleeding Disorders [ ]Alcoholism
[ ] NONE [ ]Other: _____
Explain all checked boxes:_____

REVIEW OF SYSTEMS

DO YOU CURRENTLY HAVE?

[ ]Reading Glasses [ ]Change of vision [ ]Loss of hearing [ ]Shortness of Breath [ ]Chills or Fever
[ ]Heart or Chest pain [ ]Abnormal Heartbeat [ ]Badly Swollen Ankles [ ]Calf Cramps with walking
[ ]Poor Appetite [ ]Nausea or Vomiting [ ]Stomach Pain [ ]Ulcers [ ]Bowel Incontinence
[ ]Frequent Urination [ ]Burning Urination [ ]Difficulty Starting Urination [ ]Stopping Urination
[ ]Recent Weight Change [ ]Are you Pregnant [ ]Nursing [ ] NONE

SOCIAL HISTORY

Most recent occupation or Grade in School?_____
Employer or School Name: _____
Marital Status: [ ]Single [ ]Married [ ]Divorced [ ]Separated [ ]Widowed
Children: [ ]None Number of living Sons: ____ Number of living Daughters:____
Tobacco: [ ]Yes [ ]No [ ]Quit Alcohol: [ ]Yes [ ]No [ ]Quit
Type:_____ Amount:_____
Packs/Day: _____ Frequency:_____
Do you or have you ever used illegal drugs? [ ]Yes [ ]No

TAMPA BAY ORTHOPAEDICS, P.A.

C. BARRY CRAYTHORNE, M.D.

FINANCIAL POLICY

We have found that communication with our patients regarding financial policy assists in providing the best service to you. Please take the time to read over the policy below before you sign. **PLEASE CHECK ONE THAT APPLIES TO YOU AND SIGN.**

___ Commercial/HMO/PPO Plans:

Our staff is pleased to bill your insurance company as a courtesy to you after your benefits have been verified and authorization is obtained (if required by your plan.) *It is the patients responsibility to remit any deductible, co-payment, co-insurance, or non-covered charge at the time of your service.* Should you choose to bill your own insurance, the billing office will provide you with an itemized list of service rendered during your appointment(s). However, full payment will be required at the time of each visit. *If your insurance company fails to pay within 60 days of the date of billing.* ***WE EXPECT YOU TO PAY THE BALANCE OF YOUR BILL AND SEEK REIMBURSEMENT FROM YOUR INSURANCE COMPANY.***

___ WORKER'S COMPENSATION:

All pre-authorized bills will be sent directly to the Worker's Compensation carrier. In the event that your claim is denied, you will be responsible for payment. We will gladly file any other insurance carrier that you may have as a courtesy to you.

___ MEDICARE:

This is a Medicare certified facility and we will file claims directly to Medicare. You will be expected to notify us of any other forms of insurance in which might be primary to Medicare for the treatment being provided. Such as but not limited to: Auto Insurance, Worker's Compensation, Group Insurance, HMO Medicare replacement policy, Black Lung, ETC.

___ SECONDARY INSURANCE:

As a courtesy to you, we will file your supplemental carrier for you. ***Payment will be expected from you if your supplemental insurance does not pay your deductible, co-insurance, or co-pays within 30 days of filing the claim.***

___ Private Pay:

Full payment is too expected when services are rendered to continue treatment at this facility. If this creates a financial burden to you, you **MUST** make financial arrangements with us before treatment is rendered.

AGREEMENT TO PAY

I understand and agree that I'm responsible and liable for payment of all charges assessed for professional services rendered by Dr. C. Barry Craythorne. I have read and understand the financial policy detailed above. I understand that I'm primarily responsible for all charges incurred regardless of my existing insurance coverage. In the event that my insurance forwards payment to me, I will deliver such payment to non-covered services at the time of service. Should my account become past due, the balance becomes my responsibility and is immediately due and payable. In the event that my unpaid balance is referred for outside collections, I will be responsible for all collection and legal costs. My signature authorizes release of any medical information necessary to process my claim and assigns payment to benefits to Tampa Bay Orthopaedics, P.A.

PRINT PATIENTS NAME PATIENTS SIGNATURE DATE