NOTICE OF HEALTH INFORMATION PRACTICES AND RELEASE OF PROTECT HEALTH INFORMATION

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____

I, _____

authorize Santa Rosa Orthopaedic Associates, P.A. and any of

its employees to release my protected medical information to the following:

Name	Relationship
_____	_____
_____	_____
_____	_____

Use of Answering Machine: yes no

Use of Cell Phone Voice Mail: yes no

I also acknowledge by signing this form I have received a Notice of Health Information Practices explaining how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

SANTA ROSA ORTHOPAEDIC ASSOCIATES, P.A.

PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____ Sex _____

Date of Birth _____ Age _____ Social Security # _____ Race _____ Marital Status S M W D O

Address _____

City State ZIP _____

Home Phone # _____ Work Phone # _____ Cell Phone# _____

Referring Physician _____ Primary Care Physician _____ Primary Care Telephone Number _____

Student Athlete? YES OR NO

Is this work related? YES OR NO

Employer _____ Accident Date _____

PARENT/GUARDIAN

Last Name _____ First Name _____ Middle _____ Social Security # _____

Address _____ City State Zip

IF YOU HAVE INSURANCE IN YOUR SPOUSES' OR PARENTS' NAME WE MUST HAVE THE INFORMATION REQUESTED BELOW.

PRIMARY INSURANCE CARRIER: _____

Primary Insurance Subscriber _____ Date of Birth _____ Social Security # _____ Relationship to Patient _____

SECONDARY INSURANCE CARRIER: _____

Secondary Insurance Subscriber _____ Date of Birth _____ Social Security # _____ Relationship to Patient _____

NEAREST RELATIVE NOT LIVING WITH YOU

Name _____ Phone # _____ Relationship _____

Address _____ City State Zip

Date Completed: _____

SANTA ROSA ORTHPAEDIC ASSOCIATES, P.A.

Michael T. Hartsfield, M.D., Christopher B. Bookout, M.D.
Jeanine Hellwig, ARNP

ASSIGNMENT OF BENEFITS

I, _____ hereby authorize _____
(Name of Insured/Patient) (Name of Insurance Carrier)
to make medical benefits payments, otherwise payable to me for services rendered by **Santa Rosa Orthopaedic Associates, P.A. - Michael T. Hartsfield, MD, Christopher B. Bookout M.D., and/or Jeanine Hellwig, ARNP**, payable to and mailed directly to :

SANTA ROSA ORTHPAEDIC ASSOCIATES, P.A.
5750 Berryhill Road
Milton, Florida 32570

Furthermore, I hereby IRREVOCABLY ASSIGN to Santa Rosa Orthopaedic Associates, P.A. 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 Santa Rosa Orthopaedic Associates, P.A.

Furthermore, the undersigned by these presents does hereby make, constitute and appoint Santa Rosa Orthopaedic Associates, P.A. and any of its duly authorized agents and employee as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said Santa Rosa Orthopaedic Associates, P.A. which checks, drafts or money orders are made payable for services which have been made by Santa Rosa Orthopaedic Associates, P.A. , at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows Santa Rosa Orthopaedic Associates, P.A. or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and other statements.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

MEDICAL RECORDS CONSENT

Furthermore, a photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to Santa Rosa Orthopaedic Associates, P.A. or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be binding as an original signature page

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____, 200__.

PATIENT'S SIGNATURE	**PATIENT'S PRINTED NAME**	**DATE**
WITNESS SIGNATURE	**PRINTED NAME**	**DATE**

SANTA ROSA ORTHOPEDICS
PATIENT MEDICAL HISTORY

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

How did you hear about our office? _____

HISTORY OF PRESENT ILLNESS: What are you being seen for today: _____

When did this begin: _____ Have you ever had this problem before: Y N

Has any other physician seen you for this condition: Y N Name: _____

Family Physician: _____

Physician will complete this gray area.
Acute, Chronic, Recurrent Quality: Severity: Modifying Factors (relief, aggravated by):
Assoc. Signs/Symptoms:

MEDICAL HISTORY: Please check all that apply

( ) Alcoholism
( ) Arthritis (Location) _____
( ) Asthma
( ) Blood Clots
( ) Blood Diseases ( ) Anemia ( ) Leukemia
( ) Blood Transfusion (when) _____
( ) Bronchitis
( ) Cancer (Type) _____
( ) Cataracts
( ) Colitis
( ) Diabetes
( ) Diverticulitis
( ) Drug Addition
( ) Emphysema
( ) Epilepsy
( ) Fracture/Broken Bones (where) _____
( ) Glaucoma
( ) Gout
( ) Heart Disease ( ) Mitral Valve Prolapse ( ) Murmurs
( ) Abnormal Rhythm ( ) Congestive Heart Failure
( ) Hepatitis
( ) Hernia
( ) High Blood Pressure
( ) High Cholesterol
( ) HIV Positive
( ) Kidney Disease ( ) Kidney Stones ( ) Kidney Cysts
( ) Latex Allergy
( ) Liver Cirrhosis
( ) Osteoporosis
( ) Parkinson's
( ) Peptic Ulcers
( ) Prostate - ( ) Enlarged ( ) Inflammation ( ) Cancer
( ) Psoriasis
( ) Stroke
( ) Thyroid Disease
( ) Other _____

PAST SURGERY: Please check all that apply & enter year, complications & left or right

Surgery	Year	Left or Right	Complications
( ) Appendectomy			
( ) Arthroscopy			
( ) Joint Replacement (Location):			
( ) Breast Surgery			
( ) Cataract Surgery			
( ) Carpal Tunnel			
( ) Skin Cancer			
( ) Other:			

Surgery	Year	Complications
( ) Back Surgery		
( ) Neck Surgery		
( ) Kidney Surgery		
( ) Pacemaker		
( ) Hysterectomy		
( ) Prostate Surgery		
( ) Cesarean Section		
( ) D & C		
( ) Gallbladder Surgery		
( ) Heart Bypass		
( ) Heart Valve Replacement		
( ) Tonsillectomy		

MEDICATIONS – Please list all medications you are presently taking.

Medication	Mg.	Dosage	Medication	Mg.	Dosage	Medication	Mg	Dosage
Ex. name of drug	**25Mg.**	**2 per day**						

SOCIAL HISTORY **Patient Name:** _____ **Number:** _____

Drug Allergies: _____

Have you ever-smoked tobacco: Y N How much per day? _____ When did you quit? _____

Have you ever taken drugs not prescribed by a physician: Y N What: _____

Are you currently taking any non-prescribed drugs? Y N What: _____

Are you currently taking any herbal drugs? Y N What: _____

Do you consume alcohol: Y N How much: _____

Occupation: _____

SYSTEM REVIEW: Please circle all that apply today

GENERAL: Chills Sweats Anorexia Fatigue Weight loss Weight gain
EYES: Visual changes Blurring Double vision Irritation Discharge Loss Pain in sun
EAR NOSE THROAT: Earache Ringing in ears Hearing loss Sore throat Post nasal drip Runny nose Facial pressure Painful teeth
RESP: Cough Shortness of breath Difficult breathing Coughing blood COPD Emphysema
CARDIO/VASCULAR: Chest pain Palpitations Syncope Difficulty On Exercising PND Edema Tachycardia
GASTRO INTESTINAL: Vomiting Heart Burn Reflux Anorexia Diarrhea Constipation Black stools Bloody stools, Abdominal pain
GENITAL/URINARY: Painful Urination Frequency Hesitancy Urgency Nighttime Urination Bloody Urine Sores Discharge Testicle pain
GYNOCOLOGY: Discharge Odor Pelvic pain Painful coitus Sores Irregular menses
MUSCULOSKELETAL: Back pain Joint Pain Joint swelling Muscle Pain Decreased ROM Altered gait
SKIN: Rash Itching Dryness Ulcers Bruising Bleeding under skin Redness of skin Pinpoint red/purple spots Hardened skin due to swelling
ENDOCRINE: Heat/cold intolerance Increase thirst Increase hunger Increase urination
NEUROLOGY: Weakness Abnormal sensation Painful skin Seizures Tremor Dizziness Headache
PSYCHOLOGY: Depression Anxiety Panic Memory loss Suicidal thoughts Agitation Unstable mood Insomnia Loss of contact with reality
HEME/LYMPH/ID: Abnormal bleeding Bruising Swollen glands Anemia Transfusion HIV exposure Sexually transmitted diseases _____
OTHER: _____

FAMILY HISTORY:

Please list any blood relative and their relationship to you that have had any of the following (paternal or maternal):

Diabetes _____ High Blood Pressure _____

Heart Disease _____ Rheumatoid Arthritis _____

Other _____

Physician will complete this section:

PHYSICAL EXAM: (1) 1-5 Elements (2) 6-11 elements (3) 12-17 elements (4) 2 elements from 9 areas - 18

Note findings whether positive/negative. Only dictate those examined. Areas 1-11

Height: _____ Weight: _____ Dominant hand: R L

P _____ BP _____ R _____ T _____

1. **General Appearance** (egg. Development, nutrition, body habitués, deformities, grooming, etc.)
2. **Neuro** (Sensation, DTRs / Reflexes, Coordination)

3a. Body Part affected (RT or LT): (ROM, Inspection/palpate, Stability, muscle strength/tone)

b. Opposite Site not affected (RT or LT): (ROM Inspection/palpate, Stability, muscle strength/tone)

4. **Musculoskeletal System** (Gait and station)
5. **Skin** (Inspection skin/subcu. Tissue – rashes, lesions, ulcers; Palpation of skin/subcu tissue (tightening, nodules)
6. **Cardiovascular** (Edema/varicosities)
7. **Psych** (Mood & Affect; Judgment/insight)
8. **Respiratory** (Auscultation of lungs; Assessment of respiratory efforts)
9. **Neck** (Masses/Crepitus; Thyroid tenderness/enlargement)
10. **Lymph Nodes** (Groin; Other)
11. **Additional Exams**