Dear New Patient,

Welcome! Thank you for the opportunity to assist you with your orthopaedic problem. The following information will help you prepare for you visit with Dr. Brothers.

Please bring all past medical records and any study results related to your current problem to your first visit. If you have had x-rays, MRI, CT scan, or other imaging, we need both a report and a disc with the images. You can obtain these from the facility where you had them done or have them forwarded to our office prior to your appointment. Imaging within the past 6 months only or our office will order you new x-rays prior to your appointment.

If you cannot make you appointment, please notify the office.

If you need language translation or interpreter assistance, please notify us is advance so we can make arrangements.

Please complete the enclosed new patient paperwork prior to your first appointment. You may return it via fax (850) 908-3149 or present it at your appointment. Please bring your current insurance card and driver's license to your first appointment.

We appreciate the opportunity to provide you with orthopaedic care as well as your cooperation in following the above guidelines.

Should you have any questions, please do not hesitate to call our office at (850) 908-3140. We look forward to treating your orthopaedic needs.

Sincerely,

Dr. Anthony J. Brothers and his "awesome" staff

History of Present Illness

NAME: _____

DOB: _____ AGE: _____

Occupation/Job: _____

Height: _____ ft Weight: _____ lbs

Hand Dominance:
Right handed Left handed

Patient type:
NEW PATIENT NEW COMPLAINT

Body Part (Please circle):
SHOULDER KNEE HIP OTHER: _____

Which side (Please circle):
RIGHT LEFT BOTH

SEVERITY_____ _____
How severe is the pain (O=NONE, 10=SEVERE PAIN)
AT REST: _____ AT WORST: _____

QUALITY
How would you describe the pain (Circle all that apply):
Sharp Dull Aching Throbbing
Other: _____

CONTEXT

How did you injure yourself?:

No Injury-it just started hurting

Motor Vehicle Accident
Worker's Compensation Claim
Sport Injury (which sport): _____

Briefly describe the injury: _____
_____
_____

TIMING

DURATION

What is the date of injury/onset: _____

How long have you had symptoms:

_____ days _____ months _____ years

MODIFYING FACTORS

What makes the pain better?:
_____
_____
_____

What makes the pain worse?:
_____
_____
_____

Describes your current limitations:
_____
_____
_____

Is your pain: Constant Intermittent

Associated Symptoms
Circle any signs/symptoms associated with the injury:

SWELLING	STIFFNESS
POPPING	INSTABILITY
GIVING AWAY	NUMBNESS
WEAKNESS	BURNING
CATCHING	OTHER: _____

PREVIOUS EVALUATION/TREATMENT
Diagnosis (If given): _____

Have you had: XRAYS MRI CT Scan

Previous Treatment (PT, injections, bracing, etc.) _____
_____

Prior surgery on the effected body part: _____
_____

Interested in surgery if offered? YES NO

(Continue to next page....)

MEDICAL HISTORY

PHARMACY
Name: _____

Location: _____

OTHER PROVIDERS
Referring Physician: _____ Facility: _____

Primary Care Physician: _____ Facility: _____

Cardiologist (if applicable): _____ Facility: _____

Pain Management (if applicable): _____ Facility: _____

Coach/ Athletic Trainer/Team Doctor: _____ School: _____

Contact Number: _____

PAST MEDICAL HISTORY
Please check if you have had any of these medical problems in the PAST:

MAJOR ILLNESS	YES	NO	**MAJOR ILLNESS**	YES	NO
Anemia			Liver disease		
Arthritis			Kidney disease		
Heart Palpitations			Loss of vision		
Asthma			Mitral valve prolapse		
Bleeding Disorder			Neuropathy		
Blood Clots			Paralysis		
Cancer- Type:			Peripheral vascular disease		
Chest pain/ Angina			Pneumonia		
Diabetes- Type:			Psychiatric illness		
Delayed Wound Healing			Pulmonary embolism		
Gall bladder disease			Reflux		
Gastric ulcer			Skin ulcer		
Glaucoma			Steroid use (chronic)		
Heart attack			Stroke		
Heart failure			Thyroid disease		
Hepatitis B			Tuberculosis- TB		
Hepatitis C			Urinary infections		
High blood pressure			Valve disorders (heart)		
HIV/AIDS			OTHER (explain):		
Immune deficiency					

(Continue to next page)

MEDICAL HISTORY

Please list any prior surgeries/operations you have had:

SURGERY/REASON	YEAR	SURGERY/REASON	YEAR
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Please list any MEDICATIONS you are currently taking:

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY
1)			7)		
2)			8)		
3)			9)		
4)			10)		
5)			11)		
6)			12)		

ALLERGIES

1. Do you have any ALLERGIES to medications/substances? (please list reaction type: hives, sneezing, cough)

_____

_____

2. Do you have an allergy to LATEX? YES NO

FAMILY MEDICAL HISTORY (Please list major illnesses that affect your immediate family):

MEDICAL ILLNESS	RELATION	MEDICAL ILLNESS	RELATION
1)		5)	
2)		6)	
3)		7)	
4)		3)	

SOCIAL HISTORY:

Alcohol Use: (Never) (Yes- Current) (Yes-Former) Drinks per week:_____

Cigarette Use: (Never) (Yes- Current) (Yes-Former) Packs per day:_____Years: ____

Smokeless Tobacco: (Never) (Yes- Current) (Yes-Former)

Illicit Drug Use: (Never) (Yes- Current) (Yes-Former) Type: _____

(Continue to next page)

MEDICAL HISTORY

REVIEW OF SYSTEMS (Please circle any that apply):

1. **GENERAL**

   Weight Loss Chills Fever Malaise/Fatigue None

2. **EYES**

   Vision Change Eyes Crossed Itching Pain None

3. **EARS, NOSE, THROAT**

   Loss of hearing Congestion Ringing in ear Throat pain None

4. **CARDIOVASCULAR**

   Chest pain Edema Irregular rhythm Palpitations None

5. **RESPIRATORY**

   Dyspnea Wheezing Cough None

6. **GASTRONTESTINAL**

   Change in bowel habits Constipation Nausea Abdominal pain None

7. **MUSCULOSKELETAL**

   Stiffness Joint pain Swelling None

8. **SKIN**

   Abrasions Hives Itching Lesions None

9. **NEUROLOGICAL**

   Headaches Loss of consciousness Upper/Lower Extremity Numbness None

10. **PSYCHIATRIC**

    Anxiety Depression Memory Change Mood Swings None

11. **ENDOCRINE**

    Hot/Cold intolerance Diabetes Hot flashes None

12. **HEMATOLOGICAL**

    Anemia Easy Bruising Night Sweats None

PATIENT REGISTRATION FORM

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Last Name: _____ First Name: _____ MI: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Occupation: _____

Date of Birth: _____ **Sex:** M F **Marital Status:** Married Single Divorced Widowed **Preferred Language:** _____

Race: ☐ American Indian or Alaska native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Unknown/Declined to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined to answer

Home phone: (_____)_____ cell phone: (_____)_____ work phone: (_____)_____

Best daytime number to reach you: ☐ home ☐ work ☐ cell Is it ok to leave a message at any of the numbers? ☐ Yes ☐ No

If no, please designate which ones, if any: _____

Primary Care Physician's Name (if applicable): _____ How did you hear about us? _____

Spouse's Name: _____ Date of Birth: _____ Spouse's SS#: _____

RESPONSIBLE PARTY: THIS SECTION REFERS TO THE PERSON/PARTY WHO SHOULD RECEIVE THE BILL

Relationship to Patient: ☐ Self (skip to next section) ☐ Parent ☐ Spouse ☐ Other (skip to next section) _____

Last Name: _____ First Name: _____ MI: _____

Social Security Number: _____ Birth date (mm/dd/yyyy): _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Home phone: (_____)_____ Cell phone: (_____)_____ Work phone: (_____)_____

INSURANCE INFORMATION

Primary Insurance Coverage: _____ Copay: $_____

Policy effective date: _____ Deductible: $_____ Met? ☐ Yes ☐ No If no, amount met: $ _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Subscriber: _____

Subscriber's DOB: _____ Subscriber's SS #: _____

Secondary Insurance Coverage: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Subscriber: _____

Subscriber's DOB: _____ Subscriber's SS #: _____

Disclosure to Release Information to Families/ Emergency Contacts and Physicians

I authorize Baptist Physicians Group to disclose my health care information and to discuss my health care needs with those that I designate. I further authorize the release of my billing information to the following individuals and give them the ability to pick up prescriptions and/or forms, etc., on my behalf. A photo ID is required for any pick up. These individuals will be considered my emergency contacts. Without authorization, no information may be shared.

Important Note: If you may want or need any healthcare information or scheduling information released to any individuals they need to be specifically listed below. This includes individuals such as: a parent or child of a patient over 18 years of age, your primary care physician, your insurance policy holder, and/or sport coaches etc.

I authorize Baptist Physicians Group and his staff to disclose my personal health information to the following people:

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Print Name of Patient or Guardian: _____

Relationship to patient: _____

Patient or Guardian Signature: _____ Date: _____

Patient Responsibility Agreement

Welcome to Baptist Medical Group (BMG), part of Baptist Health Care. We understand you have many choices when it comes to health care and we are glad you chose our medical group. We look forward to providing you with quality health care that is accessible, comprehensive, team-based, coordinated, and focused on your health and safety. Please review the following patient responsibilities, sign and return.

OBLIGATION TO PAY MY BMG BILL: I understand that all charges for services rendered by BMG are due and payable at the time of service. If I have health care insurance, I agree to pay for any deductibles, co-payments and the patient responsibility portion of the fee at the time of service. I acknowledge that I am financially responsible for my BMG bills (or, if signed by a guarantor, the guarantor is responsible) which are not paid for by my health insurance plan, and I agree to pay the bill promptly.

MEDICAL INSURANCE: I acknowledge that billing my health plan is a service provided by BMG. I will inform BMG of any changes in address or phone number for myself and/or responsible party, present my photo ID and all insurance identification cards upon request. I understand I may be responsible for the entire BMG bill if my health plan refuses to pay after reasonable attempts to collect from the health plan.

APPOINTMENTS: I agree to bring a list of all medications I am currently taking to each appointment. I agree to check in on time for my appointment. I understand that if I am late for my appointment, I will be re-scheduled for the next available appointment time and understand there may not be an appointment available the same day. I agree to notify the office at least 24 hours in advance of my appointment if I find I must cancel my appointment. I understand that failure to notify the office 24 hours in advance will result in a $25.00 missed appointment fee, which cannot be billed to insurance. I understand my patient/physician relationship may be terminated if I miss more than three appointments.

AUTHORIZATIONS AND REFERRALS: I understand that I am responsible for notifying the practice if my health plan requires pre-authorizations for tests or for referrals to specialists. I understand the BMG office staff may assist me with scheduling referrals and/or diagnostic testing but failure to obtain necessary authorizations before the scheduled appointment may result in the visit/test needing to be rescheduled and/or charges being billed directly to me.

FINANCIAL ASSISTANCE: I understand there are financial assistance programs available for patients who are unable to pay for their care based upon a determination of financial need in accordance with the BMG financial assistance policy. I understand it is my responsibility to contact a Patient Account Specialist at BMG's business office at (850) 475-3500 to request financial assistance. I agree to provide my personal financial information and/or submit to a credit check to determine if I qualify for financial assistance. If I do not qualify for financial assistance and do not have health insurance, I understand and agree that I will pay in full for all services at the time of service. If I do not have insurance, a 30% discount will be applied when full payment is made at time of service.

RETURN CHECK POLICY: I understand I will be responsible for all service charges and collection fees associated with collecting any bad check I write to BMG and will pay these fees upon notice.

NON-PAYMENT ON ACCOUNT: I understand that if my BMG account has a balance due older than 90 days old, it may be placed with an outside agency for collection and all relevant personal and account information necessary to collect payment for services will be revealed. I understand that I am responsible for all fees for collecting these past due balances including, but not limited to, collection fees, court costs and attorney fees. I understand BMG may, upon written notice, terminate the patient / physician relationship due to non-payment on account.

BUSINESS HOURS: I understand unusual circumstances will sometimes require the office hours to be changed without notice. I understand the pre-recorded telephone message will let me know when to call back for routine requests and what to do in case of an urgent medical need (one that does not require emergency treatment). I understand that I should call 911 in the event of a medical emergency or proceed to the closest emergency room for treatment.

PRESCRIPTIONS AND/OR REFILLS: I understand that requests for new medication and/or refills should be made during my visit with my provider If I need a prescription refill between visits, I agree to contact my pharmacy and allow 48 to 72 business hours to process. I understand refill requests will only be processed during office hours. I understand that narcotic prescriptions are highly regulated and may require a signed narcotics agreement between me and my provider. I agree to carefully read all stipulations in the narcotics agreement and abide by these. I understand that my physician will refill narcotics only when appropriate and only during the office visit; no refills after hours and no refills via phone request.

PATIENT FORMS COMPLETION: I understand that an office visit may be necessary if I request the provider complete certain forms for me. There is also a nominal fee, payable in advance, for the completion of these forms. I understand these requests may take up to 14 days for processing.

MEDICAL RECORDS: I understand that in compliance with applicable state and federal law, in some cases, appropriate authorization forms must be completed and signed by the patient before records are released. Florida law allows office practices to charge a fee for providing these medical records to cover labor, equipment and supplies, which will be collected prior to the release of medical records.

PATIENT PORTAL: I understand many of the BMG practices have a patient portal to offer me a secure online website for convenient 24-hour access to my personal health information. This is an optional program using a secure username and password. Recent doctor visit notes, medications, contact information and health records can be viewed and printed. The office staff can provide more information regarding the Patient Portal.

WIRELESS COMMUNICATION: By providing a wireless or mobile telephone number, I give permission to BMG to use this number for contact. Contact includes receiving calls and messages, including pre-recorded messages and calls via an automatic telephone dialer from BMG and their authorized agents.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE ABOVE PATIENT RESPONSIBILITIES.

Patient/Guardian Signature	**Date**
Print Patient/Guardian's Name from above	**Guardian's relationship to patient**

Thank you again for choosing Baptist Medical Group