Dear Patient or Guardian,

Please read all information provided.

Please note, it is the patient's or financially responsible party's responsibility to ensure Dr. Andrews (tax ID#: 743018052) and the Andrews Institute Ambulatory Surgery Center (tax ID#: 352274952) (if needed) and Paradigm Anesthesia (tax ID#: 205877557) (if needed), are covered by your insurance policy. **Do not** request pre-authorization, as you are unable to obtain this information. Our staff will obtain any pre-authorization or pre-certification, should it be required.

Please call the customer service number on the back of your insurance card and give them the tax ID numbers for the appropriate providers. Please do not use the name of the provider.

Our office will verify your benefits; however, due to the volume of patients Dr. Andrews sees, we may not have your benefits verified until the day before or the day of your appointment.

You may receive statements and/or bills from the following entities:

Andrews Institute ASC- ambulatory surgery center fees (only if having surgery)

Paradigm Anesthesia- anesthesia services (only if having surgery)

Gulf Breeze Hospital- labs, imaging, physical therapy, etc.

Baptist Physician's Group- DME (braces, splints)

Jeremy Geus, ATC, CSCS
Regional Practice Coordinator

1040 Gulf Breeze Parkway Suite 203 Gulf Breeze, Florida 32561
Tel: 850.916.8775 Fax: 850.916.8764
www.andrewsinstitute.com

Dear Patient,

It is important that you follow the guidelines listed below in order to help ensure you are seen in a timely manner and that correct data regarding your visit is obtained.

- The first 45-60 minutes of your appointment will be spent with check-in, chart completion, insurance verified, and preparing images.
- If you can not make your appointment, we respectively ask that you notify our office forty-eight (48) hours in advance. If, for some unforeseen reason, you are late for your appointment, please call ahead and notify our office (850-916-8775). You may be asked to reschedule to a later date and time.
- It is mandatory that you send all insurance cards, forms, drivers' licenses and insurance policy numbers in advance your appointment so that the proper billing and insurance certifications and authorizations may be obtained. Please fax this information to 850-916-8764 or email to Stephanie.Smith@bhcpns.org.
- If your insurance requires a referral from your primary care physician, you should request before scheduling. If you are not sure about what insurance plan you participate in, please contact your employer's Human Resources office.
- Registration paperwork and accident/injury forms should be printed, completed and returned as soon as possible. The fax number, mailing address, and email addresses are listed on the email that contains these forms.)
- It is the patient's responsibility to obtain previous medical records (MRI reports, surgical reports, office notes, etc.) or diagnostic testing (MRIs, EMG studies, X-rays, etc). Past medical information must be received before our staff can schedule your appointment.
- If you do not have current images and/or diagnostic tests (6 months or less), you may be asked to schedule with another physician in our practice to obtain these materials prior to your visit with Dr. Andrews.
- Procedures are performed on an outpatient basis; however, you may be asked to stay at a local hotel, for up to 7 days following surgery.
- If you are scheduled for a surgical procedure, you MUST be accompanied by someone over the age of 19 the day of surgery; additionally, anyone under 19 years of age MUST be accompanied by a parent or legal guardian; there will be no exceptions. If you do not have a responsible adult with you at the time of discharge, we will provide contact information for a local home health nursing service, that you will arrange, at your expense.
- If you need language translation or interpreter assistance, we will arrange at your expense. Please let us know in advance.
- If you take NSAIDS (non-steroidal anti-inflammatory medications) you must stop taking 7 days prior to your procedure.
- Appropriate attire includes: athletic shorts, t-shirt or tank tops, sports bra for females with upper extremity problems.

We appreciate the opportunity to provide you with orthopedic 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) 916-8775.

Sincerely,
Jeremy Geus, ATC,CSCS
Practice Coordinator

I __________________________________ (your name), have read and understand the information and instructions in the previous three pages.

X ____ Date _____________________

To: Andrews Institute **From:** ______________________

Fax: 850-916-8764 **Phone:** ______________________

Thank you for choosing Andrews Institute for Orthopaedics & Sports Medicine.
To expedite the check-in process for our new patients, we ask that you take time to complete our new patient forms beforehand and either fax them to (850) 916-8764 or send them via e-mail to ***stephanie.smith@bhcpns.org*** .

Things to send before your appointment:

- ☐ Patient Forms, insurance cards (primary and secondary), school insurance information and contacts
- ☐ Previous medical records, operative reports, MRI reports, or other diagnostic testing information

Things to bring to your appointment:

- ☐ Insurance Card
- ☐ Driver's License
- ☐ Change of clothes (athletic shorts, t-shirt or tank tops, sports bra for females with upper extremity problems)
- ☐ Recent X-rays and MRI's (if not taken at a Baptist facility)

Our location: 1040 Gulf Breeze Pkwy, Suite 203
Gulf Breeze, FL 32561

Turn into the entrance for Gulf Breeze Hospital. Take your first left and follow the signs for the Andrews Institute. Upon entering the Andrews Institute, proceed to the right of the waterfall towards the elevators. Take the elevator to the second floor and turn left, we are located in Suite 203.

Please call us at **(850) 916-8775** if you have any questions.

We look forward to seeing you!

EXPLANATION OF ACCIDENT OR INJURY

Patient Name: ____

Body Part:____

How did you become injured:____

____

____

When did the accident/ injury/ chronic pain begin:

______________	______________	______________
month	day	year

Please check whether this was an:

□ accident □ injury □ chronic pain

Where did the accident/injury occur:

____

**Is there any litigation pending or any legal aspects of this injury?

□ YES □ NO

If answered YES, against whom? ___________________________________

Signature: ____

Date: _____________________________

Worker's Compensation Insurance Information Form

*Date of Service: ______/______/________

*Patient Name:____ * DOB: ______/______/_________

*Subscriber's SS#: ______-______-_________

*Date of Injury: ______/______/_________

*Name of Worker's Comp Carrier: ____

Is there an open claim? ☐ yes ☐ no

*Claim #: __________________________________

*Contact Person: ____ *Phone #: ______-______-________

*Adjuster(if different):_____________________________________ *Phone #: ______-______-________

*Patient's Place of Employment: ____

Chief Complaint Form: **Date: _______________**

Patient Name: ___________________ _____________________ _________________________ ______________________
First MI Last Preferred Name

Occupation: ____ Employer:____________________________________

Student ☐ School: ____

Body part being seen for: ____

Side of Body: (circle) Right Left Both

Date Symptoms Began: ___________________________

Motor Vehicle Accident? (circle) Yes No Workers Comp? (circle) Yes No

Date of Injury: _______________________________

If so, how did it happen? ____

____

____

(Complete _only_ if your records need to be forwarded)

* Referring Physician: ____ Town: ___________________________________

Contact: ______________________ ___________________________ _________________________
Email Fax Phone

* Primary Care Physician: ____ Town: _______________________________

Contact: ___________________________________ __________________________ ______________________
Email Fax Phone

* Coach/Trainer/Team Doctor: ____________________________________ School: ______________________________

Contact: _________________________________ ___________________________ ______________________
Email Fax Phone

Medical History:

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 Arrythmia/Palpitations			Loss of Vision		
Asthma			Mitral Valve Prolapse		
Bleeding Problems			Neuropathy		
Blood Clots			Paralysis		
Cancer: Type ________________			Peripheral Vascular Disease		
Chest pain/Angina			Pneumonia		
Diabetes			Psychiatric Illness		
Gall Bladder Disease			Pulmonary Embolism		
Gastric Ulcers			Reflux		
Glaucoma			Skin Ulcer/Breakdown		
Heart Attack			Steroid Use		
Heart Failure			Stroke		
Heart Murmur			Thyroid Disease		
Hepatitis B			Tuberculosis – TB		
Hepatitis C			Urinary Infections		
High Blood Pressure			Valve Disorders (heart)		
HIV/AIDS			Wound Healing Problems		
Immune Deficiency			OTHER:		

Please list any **operations/surgeries** you have had:

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

Please list any **Medications** that you are currently taking:

MEDICATION	DOSE	DOCTOR	**MEDICATION**	DOSE	DOCTOR
1)			6)		
2)			7)		
3)			8)		
4)			9)		
5)			10)		

Do you have any **allergies** to medications/substances? Yes No

____

Latex Allergy: Yes No

History of staph/MRSA: Yes No

Family Medical History: Please list major illnesses that affect immediate family:

MEDICAL ILLNESS	RELATION	**MEDICAL ILLNESS**	RELATION
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Family History of Blood Clots: Yes No

Social History:

Alcohol use: Yes No Drinks per week: ____________

Cigarette use: Yes No Packs per day:___________ Years: __________

Smokeless Tobacco use: Yes No Years: ______________

Illicit Drug use: Yes No Type: ___________________________________

Review of Symptoms: Please mark any of the symptoms that apply to you:

SYMPTOM	YES	NO	**SYMPTOM**	YES	NO
Tarry Stools			Frequent Urination		
Vomiting			Urgent Urination		
Abdominal Pain			Painful Urination		
Chest Pain			Muscular Weakness		
Irregular Heart Beat			Numbness or Tingling		
Rapid Heart Beat			Joint Pain or Swelling		
Swelling of Legs			Muscle Pain or Swelling		
Cough			Frequent/Easy Bruising		
Shortness of Breath			Cuts that don't stop Bleeding		
Rash			Anxiety		
Wound Healing Problem			Depression		
Fever/Chills			OTHER:		

Agreement of Accuracy: The information provided in this history form is true and complete to the best of my knowledge.

X ____ Date: _____________

Patient Demographics:

Patient Name: ____ ____________________________

First MI Last Preferred Name

SSN#: ________________ Birth Date: _______________ Sex: Male Female

Address: ___________________________________ ________________________ __________ ____________

Street Address City State Zip Code

Home #: ___________________ Cell #:__________________ Work #: ___________________

Marital Status: Married Single Divorced Widowed

Race: African American Asian White Hispanic Other

Ethnicity: Hispanic or Latino Non-Hispanic or Latino

Email Address: ____

How were you referred to our practice? (Circle)

Friend/Relative: ___________ Physician Newspaper Radio Healthsource

Guardian Information: (If Patient is a Minor)

Name: ______________________________ Relationship to Patient: _______________________

SSN#: ________________ Birth date: ________________ Sex: Male Female

Address: ___________________________________ ________________________ __________ ____________

Street Address City State Zip Code

Home #: _________________ Cell #: __________________ Work: _________________

Payment Information:

Form of Payment: Health Insurance Auto Insurance Worker's Compensation Self Pay

Primary Insurance

Primary Insurance Company: ______________________ Insured's Name _______________________

Policy #: ________________ Group #: _____________ Insured's Date of Birth: ______________

Secondary Insurance

Secondary Insurance Company: ______________________ Insured's Name ______________________

Policy #: ________________ Group #: _____________ Insured's Date of Birth: ______________

Self-Pay Agreement

I agree to pay for medical services rendered at Andrews Orthopaedic and Sports Medicine facilities. I understand that there are payment plans available at my request.

X ____ Date: __________________

Release of Information: I authorize Andrews Orthopedic and Sports Medicine Center to release medical information requested by my health insurance, Medicare, or third- party payers in order to assist in the payment of claims.

X ____ Date: __________________

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 will 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 parents or child of a patient over 18 years of age, your primary care physician, your insurance policy holder, and/or sport coaches.

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 #: __________________