KATZ
ORTHOPAEDIC
INSTITUTE

14153 Yosemite Dr.
Suite 103
Hudson, FL 34667
(727) 869-BONE (2663)

WELCOME To KATZ Orthopaedic Institute

To save time on your appointment day, we have enclosed an information packet. **Please fill out all information on all forms.** Please be sure to bring these forms with you on the day of your appointment. Also, our office tends to be cold, so you may want to bring a sweater with you.

PLEASE BRING YOUR INSURANCE CARDS WITH YOU! We must have a copy of it to file your insurance. We also request picture identification.

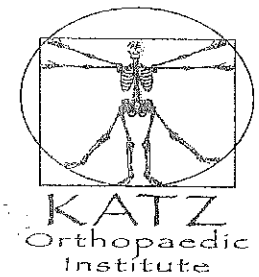
Unless special arrangements are made ahead of time, ALL co-payments, deductibles and non-covered services are due at the time of service.

We have a long waiting list of people waiting for appointments. **If you cannot keep your appointment, PLEASE give us 24 hours notice for cancellation.**

Thank you for choosing our practice, and we look forward to seeing you.

Sincerely,

Katz Orthopaedic Institute



WELCOME

Thank you for selecting our healthcare team!
To help us meet your orthopaedic needs please fill out this form completely.

14153 Yosemite Drive, Suite 103, Hudson, FL 34667
727-869-2663 Fax 727-869-2660

How did you hear about us? ☐ Friend/Family ☐ Yellow Pages ☐ TV/Advertisement
☐ Referred by Dr. _____ City _____ State _____
Your Primary Care Physician is _____ Phone # _____

****

Date _____ Chart # _____
Patient's Name: First _____ MI _____ Last _____
Address _____ City _____ State _____ Zip _____
DOB _____ SS # _____ ☐ Married ☐ Single ☐ Female ☐ Male
Home # ( ) _____ Mobile # ( ) _____ Work # ( ) _____
Driver's License # _____ E-mail Address _____

Employer Name: _____ City _____
Best time to reach you? Time _____ Day of Week _____

In the event of an emergency please contact:
Name _____ Relationship to Patient _____
Home # ( ) _____ Mobile # ( ) _____ Work # ( ) _____

Place of Injury ☐ Work ☐ Auto ☐ Other _____
Current Problem (area of body) _____
Left side _____ Right side _____ State injury occurred in _____
Is this visit related to an accident or a specific event? ☐ Yes ☐ No If Yes, date of injury _____
Workers Compensation ☐ Yes ☐ No Claim # _____ Lawsuit Involved ☐ Yes ☐ No
W/C Agency/Agent Representing you _____ Phone # _____

***Responsible Party* IF DIFFERENT FROM PATIENT**
Name _____ Relationship to Patient _____
DOB _____ SS # _____ ☐Male ☐ Female
Home # ( ) _____ Mobile # ( ) _____ Work # ( ) _____
Employer Name _____ City _____

Primary Insurance (Please provide insurance card for us to copy) **Co-Pay Amount $** _____
Insurance Company Name _____ Contract ID # _____
Name of Insured (as it appears on the card) _____ SS # _____
Relationship to Patient _____ DOB _____ Group # _____

Secondary Insurance (Please provide insurance card for us to copy) **Co-Pay Amount $** _____
Insurance Company Name _____ Contract ID # _____
Name of Insured (as it appears on the card) _____ SS # _____
Relationship to Patient _____ DOB _____ Group # _____

Date _____ Chart # _____

Patient's Name: First _____ MI _____ Last _____

PLEASE COMPLETE ALL AREAS INSIDE THIS BOX:

1) Was this an accident ☐ Yes If an accident what Date _____ ☐ No (if no, go to # 3)
2) If an accident, please explain how it happened _____
_____
3) If not an accident, when was the onset of today's condition? _____
_____
4) Specific location of injury or pain: Right _____ Left _____ Location _____
5) Is pain sharp / dull, constant / occasional? _____
6) What are your symptoms? _____
_____
7) On a scale of 1 to 10, 10 being the worst, what is the severity of your pain? _____
8) What activities make the problem feel worse? _____
or better? _____
9) How long have you experienced this problem? _____
10) If you have had an X-ray, MRI, PT or Injections in the last 60 days for this problem, please list those Here _____

Attorney representing you _____ Phone _____

****

MEDICAL HISTORY:

Please list any other Medical Conditions: (i.e. Hypertension, Diabetes) _____
_____
_____
_____

Please list prior surgeries _____
_____
_____
_____

Have you ever been diagnosed/treated for any other conditions/illness not listed above? _____
_____
_____

Women: Is there any chance you are pregnant? Yes ☐ No ☐ Date of last menstrual period _____

Did you bring x-rays or MRIs with you? ☐ Yes ☐ No Facility Name? _____

Pharmacy Name _____ Phone # _____

Date _____ Chart # _____

Patient's Name: First _____ MI _____ Last _____

List all medications that you are currently taking (prescription and non-prescription):

Medication Name	Dosage	Times / Day

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ Yes ☐ No Latex Allergy? ☐ Yes ☐ No

List any medications that you are allergic to and the reaction it causes: _____

_____

_____

SOCIAL HISTORY:

Occupation: _____ Currently Working Yes ☐ No ☐ Education: _____

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Number of Children _____

Exercise Level: _____ Diet: _____ General Stress Level: _____

Do you smoke? Yes ☐ No ☐ # of Years _____ Packs per day _____ Since what age? _____

Do you drink alcoholic beverages? Yes ☐ No ☐ Drinks per week _____

Caffeine intake: (per day) _____ Chewing tobacco: Yes ☐ No ☐ Seat belt used: Yes ☐ No ☐

Illicit drugs: Yes ☐ No ☐ if yes, type: _____

Spiritual or Cultural Preference? _____ Living Will? ☐ Yes ☐ No

Healthcare Proxy? ☐ Yes ☐ No Name _____

Power of Attorney for Healthcare ☐ Yes ☐ No Name _____

If you have a Power of Attorney, please provide a copy of your POA for your chart. Do NOT Resuscitate? ☐ Yes ☐ No

I hereby certify by my signature that the medical information given on this form is correct to the best of my knowledge.	
Patient Signature:	**Date:**

Date _____ Chart # _____

Patient's Name: First _____ MI _____ Last _____

Age _____ Height _____ Weight _____

HISTORY

	MATERNAL	PATERNAL
Heart		
Lung		
Stomach		
Liver		
Kidney		
Anemia		
Diabetes		
Mental Illness		

	MATERNAL	PATERNAL
Cancer		
Bleeding Disorder		
Epilepsy/Convulsions		
Stroke		
Thyroid		
Blood Pressure		
Other		

EXPLAIN all YES answers _____

Have you recently had or do you now have:

	YES	NO
CONSTITUTIONAL		
Night Sweats		
Fever		
Significant Weight Gain		
Significant Weight Loss		
EYES		
Dry Eyes		
Irritation		
Wear Glasses		
Change of Vision		
EAR/NOSE/THROAT/MOUTH		
Difficulty Hearing		
Ear Pain		
Frequent Nosebleeds		
Nose/ Sinus Problems		
Sore Throat		
Bleeding Gums		
Snoring		
Dry Mouth		
Oral Abnormalities		
Mouth Ulcer		
Teeth Abnormalities		
Mouth Breathing		
CARDIOVASCULAR		
Chest Pain		
Arm Pain on Exertion		
Shortness of Breath When Walking		
Shortness of Breath When Lying Down		
Heart Palpitations		
Known Heart Murmurs		
Light Headed Upon Standing		
RESPIRATORY		
Cough		
Wheezing		
Shortness of Breath		
Coughing up Blood		
Sleep Apnea		

	YES	NO
GASTROINTESTINAL		
Abdominal Pain		
Vomiting		
Change in Appetite		
Black or Tarry Stools		
Frequent Diarrhea		
Vomiting Blood		
Diarrhea		
URINARY SYSTEM		
Urinary Loss of Control		
Difficulty Urinating		
Increased Urinary Frequency		
Blood in Urine		
MUSCULOSKELETAL		
Muscle Aches		
Muscle Weakness		
Arthralgia/ Joint Pain		
Back Pain		
Swelling in Extremities		
INTEGUMENTARY/SKIN		
Abnormal Mole		
Jaundice		
Rash		
Itching		
Dry Skin		
Growth/ Lesions		
NERVOUS SYSTEM		
Loss of Consciousness		
Weakness		
Numbness		
Seizures		
Dizziness		
Frequent or Severe Headaches		
Migraines		
Restless Legs		

	YES	NO
PSYCHIATRIC		
Depression		
Sleep Disturbances		
Restless Sleep		
Feeling Unsafe in Relationship		
Alcohol Abuse		
Bipolar		
Schizophrenia		
ENDOCRINE		
Fatigue		
Increased Thirst		
Hair Loss		
Increased Hair Growth		
Cold intolerance		
Thyroid		
Diabetes		
BLOOD/LYMPH SYSTEM		
Swollen Glands		
Easy Bruising		
Easy Bleeding		
ALLERGIES		
Runny Nose		
Sinus Pressure		
Itching		
Hives		
Frequent Sneezing		
MALE		
Penile Discharge		
Prostate Trouble		
Dysuria		
FEMALE		
Regular Periods		
Menopausal		
Hysterectomy		
Vaginal Discharge		

GUARANTEE OF ACCOUNT

Katz Orthopaedic Institute requests payment for co-pays and deductibles at time of service. Your contract with your insurance carrier, depending on the type of insurance and the carrier, states that you are responsible for co-pays and deductibles at the time of service and Katz Orthopaedic Institute also has an agreement with your carrier to collect such fees at time of service. If your carrier has not paid your account with Katz Orthopaedic Institute within 60 days we ask that you pay the balance and seek settlement direct from your carrier.

If you are not covered by health insurance please ask the Katz Orthopaedic Institute personnel about a possible reduction in your fee for a cash payment at time of service.

If you have some other extenuating circumstance that leaves you unable to pay please ask the Katz Orthopaedic Institute personnel about possible resolution of debt.

I hereby authorize and assign payment directly to Katz Orthopaedic Institute and each physician in the Group individually for any medical/surgical benefits, injury benefits due because of third party liability, or proceeds of all claims resulting from the liability of the third party until such time as the account is paid in full upon the completion of treatment. By signing this form, I accept responsibility for reasonable costs incurred if my account becomes delinquent. I have read, understand and agree with the above.

X _____ _____

Signature of Patient and/or Authorized Representative — Date

PATIENT SIGNATURE AUTHORIZATION / RELEASE OF INFORMATION

I hereby consent to and authorize Katz Orthopaedic Institute to furnish any insurance company, organization, hospital, physician or pharmacist any information requested with respect to any physical or mental condition and/or treatment of me or my child.

I understand the information obtained by this authorization will be used to determine eligibility for insurance and eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize.

I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

X _____ _____

Signature of Patient and/or Authorized Representative — Date

CONSENT FOR MEDICAL / EMERGENCY TREATMENT

I hereby consent to and authorize Katz Orthopaedic Institute personnel or its contractors to render usual and customary medical/emergency treatment to me. I understand the treatment provided will be in accordance with the standard of care at the time the care is provided, including but not limited to office visits, surgical procedures and interpretations of x-rays and MRIs.

X _____ _____ _____

Signature of Patient and/or Authorized Representative — Date — Witness

ACKNOWLEDGEMENT TO USE AND DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand and have been offered a Katz Orthopaedic Institute Notice of Privacy Practices that provides a more complete description of information uses and disclosures; that I have the right to review the notice prior to signing this acknowledgement; that Katz Orthopaedic Institute reserves the right to change its notice and practice.

Please list any person that may be given your personal health information:

_____

X _____

Signature of Patient and/or Authorized Representative Date Witness

☐ Good faith attempt has been made to provide the patient with our Notice of Privacy Practices.

X _____ _____ _____

Katz Orthopaedic Institute Employee Signature Date Witness

ADDITIONAL FEE NOTICE

NO SHOW FEE: $50.00 (YOU WILL RECEIVE ONE WARNING THIS APPLIES TO THE 2ND NO SHOW WITHOUT A 24 HOUR NOTICE AND MUST BE PAID PRIOR TO NEXT VISIT)

INSUFFICIENT FUND FEE: $50.00 (Will be applied to any NSF checks and we will not be able to take anymore checks from you-CASH or CC ONLY)

FORM FEE: $15.00 (This includes any FMLA, Disability, Out of work, etc)

I hereby acknowledge the additional fees that may incur.

X _____ _____

Signature of Patient and/or Authorized Representative Date

As a patient of Katz Orthopaedic Institute, you should be aware that you may be referred to a health care facility with which physician of Katz Orthopaedic Institute may have an ownership, investment and/or financial relationship. You are; however, free to choose to obtain health care services elsewhere from another provider of your choice, and you may request to be provided with a list of alternative providers, if any, that may be available. You will not be treated differently by Katz Orthopaedic Institute, regardless of whether you choose to obtain health care services elsewhere.