Name:
Chart:
Date:

KENNEDY - WHITE ORTHOPAEDIC CENTER

PATIENT INFORMATION

PATIENT				Please Print
NAME LAST	FIRST	MIDDLE INITIAL	AGE	TODAY'S DATE
STREET ADDRESS	CITY	STATE	ZIP	
HOME PHONE	WORK PHONE	SEX	MARITAL STATUS	DATE OF BIRTH	CELL PHONE #
EMAIL ADDRESS				
OUT OF STATE # ( )	OUT OF STATE ADDRESS	CITY-STATE-ZIP		
EMPLOYER NAME AND ADDRESS	CITY-STATE-ZIP			
SOCIAL SECURITY NUMBER	OCCUPATION / STUDENT			
FAMILY PHYSICIAN	REFERRED BY			

SPOUSE, OR IF YOU ARE A MINOR, YOUR PARENT OR GUARDIAN			
NAME FIRST-MIDDLE-LAST (IF MINOR, FATHER'S NAME)	RELATIONSHIP	SPOUSE/PARENT DATE OF BIRTH	
STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE # ( )	WORK PHONE # ( )	SOCIAL SECURITY #	

NEAREST RELATIVE NOT LIVING WITH YOU	MUST BE COMPLETED		
PERSON TO CONTACT IN EMERGENCY (NEXT OF KIN)	THEIR RELATIONSHIP TO YOU	HOME PHONE	WORK PHONE
STREET ADDRESS	CITY-STATE-ZIP		

INSURANCE INFORMATION			SECONDARY CARRIER		
INSURANCE COMPANY **WORKERS COMPENSATION**	PHONE	☐ HMO COPAY$___ ☐ PPO COPAY$___	INSURANCE COMPANY	PHONE	☐ HMO COPAY$___ ☐ PPO COPAY$___
INS. CLAIMS MAIL TO:			INS. CLAIMS MAIL TO:		
STREET			STREET		
CITY/STATE/ZIP	ADJUSTER NAME		CITY/STATE/ZIP	ADJUSTER NAME	
POLICY #	☐ AUTHORIZATION ☐ REFERRAL	☐ CLAIM #	POLICY #	☐ AUTHORIZATION ☐ REFERRAL	☐ CLAIM #
GROUP #			GROUP #		
INSURED PERSON	SS #		INSURED PERSON	SS #	
INSURED PERSONS DATE OF BIRTH			INSURED PERSONS DATE OF BIRTH		

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS	MEDICARE AUTHORIZATION TO RELEASE INFORMATION AND MEDICARE ASSIGNMENT
I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits to Kennedy - White Orthopaedic Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.	I request that payment of authorized Medicare benefits be made on my behalf to Kennedy - White Orthopaedic Center for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I AGREE
SIGNATURE (parent if minor) DATE	SIGNATURE (parent if minor) DATE

Name:
Chart:
Date:

KENNEDY-WHITE ORTHOPAEDIC CENTER

PATIENT HISTORY

Patient Name: _____

Age: _____ Sex: _____ Height: _____ Weight: _____

Date of Birth: _____

Your Occupation: _____

Who Referred You To Our Office? _____

Personal Physician: _____

MEDICAL HISTORY

Y	N	
☐	☐	**PACEMAKER**
☐	☐	**ON COUMADIN**
☐	☐	**ON ASPIRIN**
☐	☐	**OTHER BLOOD THINNERS**
☐	☐	rheumatoid arthritis
☐	☐	lupus arthritis (SLE)
☐	☐	ankylosing spondylitis
☐	☐	arthritis (other)
☐	☐	fibromyalgia
☐	☐	osteoporosis
☐	☐	polymyalgia rheumatica (PMR)
☐	☐	gout
☐	☐	psoriasis
☐	☐	**HEART DISEASE**
☐	☐	heart attack
☐	☐	angina
☐	☐	**HIGH BLOOD PRESSURE**
☐	☐	atrial fibrillation
☐	☐	stroke
☐	☐	peripheral vascular disease
☐	☐	asthma/ emphysema/ COPD
☐	☐	TB (tuberculosis)
☐	☐	pulmonary embolus
☐	☐	blood clot in leg (DVT)
☐	☐	**DIABETES**
☐	☐	neuropathy
☐	☐	thyroid disease
☐	☐	HIV (AIDS)
☐	☐	kidney failure
☐	☐	stomach ulcer
☐	☐	gastric bleeding
☐	☐	reflux (GERD)
☐	☐	hepatitis
☐	☐	liver disease
☐	☐	**CANCER**, list type(s)
		_____
☐	☐	seizure disorder (epilepsy)
☐	☐	multiple sclerosis
☐	☐	Parkinson's disease
☐	☐	dementia
☐	☐	depression
☐	☐	bipolar disorder
☐	☐	anxiety disorder
☐	☐	mental illness
☐	☐	Other: _____

PREVIOUS SURGERIES

Y	N	
☐	☐	prior problems with anesthesia
☐	☐	gallbladder
☐	☐	appendix
☐	☐	prostate
☐	☐	hysterectomy/ovaries
☐	☐	heart stents
☐	☐	heart bypass
☐	☐	heart valve surgery
☐	☐	spine surgery
☐	☐	hip surgery
☐	☐	knee surgery
☐	☐	shoulder surgery
☐	☐	hand surgery
☐	☐	other surgeries (list):

_____
_____
_____
_____
_____
_____

REVIEW OF SYSTEMS

(Please check YES or NO as they apply to the previous year)

Y	N	
☐	☐	chest pain
☐	☐	shortness of breath
☐	☐	night sweats/fever
☐	☐	weight loss (unintentional)
☐	☐	heartburn caused by medicine
☐	☐	blurred vision
☐	☐	blood in urine
☐	☐	burning on urination
☐	☐	skin rash
☐	☐	loss of hearing
☐	☐	easy bleeding/bruising
☐	☐	seizures/convulsions
☐	☐	loss of memory
☐	☐	claustrophobia
☐	☐	dizziness
☐	☐	nausea/vomiting
☐	☐	numbness hands/feet

SOCIAL HISTORY: Married ☐ Single ☐ Partner ☐ Divorced ☐ Widow/Widower ☐

Number of Children: _____

Presently living alone? Yes ☐ No ☐

With which hand do you write: right ☐ left ☐ both ☐

Do you currently use a cane or walker? Yes ☐ No ☐

Do you smoke? Never ☐ Yes ☐ No ☐

If no, when did you quit: _____

If yes, how many packs per day: _____

If yes, how many years: _____

Alcohol:

Never ☐ Never, but I used to ☐

Occasional ☐ Moderate-to-heavy use ☐

# of drinks per day _____

Prior Alcohol Abuse Problem ☐

Drug Problem:

Never ☐ Present ☐ Past Problem ☐

Name:

Chart:

Date:

Are you allergic to any medications? Yes ☐ No ☐

If yes, list medication(s) & the reaction:

Medication	**Allergic Reaction**

Current Medications:

Drug Name	**Form (tablet, liquid, etc.)**	**Dose**	**Frequency**

FAMILY HISTORY

	Yes	No	If Yes, check all to whom it applies					
			Family	Father	Mother	Sibling	Child	Other
Hepatitis	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐
AIDS	☐	☐	☐	☐	☐	☐	☐	☐
TB	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐	☐	☐	☐	☐

Name:
Chart:
Date:

NEW PATIENT QUESTIONNAIRE

Sean R. Dingle, M.D.

Patient Name: _____

Date: _____

Describe problem being seen for today: _____

_____

When did your problem start? _____

Was it from an accident? ☐ no ☐ yes _____

Pain started ☐ suddenly ☐ gradually ☐ pushing ☐ pulling ☐ playing sports

How often do you feel pain? ☐ constantly ☐ daily ☐ weekly ☐ monthly

Have you been treated for this before? ☐ no ☐ yes _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

What treatments have you had?

- ☐ physical therapy
- ☐ modalities
- ☐ ultrasound
- ☐ electrical stimulation
- ☐ anti-inflammatories (Motrin, Advil, Celebrex, etc)
- ☐ cortisone shots
- ☐ other

What tests have you had done?

- ☐ x-ray
- ☐ CT scan
- ☐ MRI
- ☐ EMG
- ☐ Other: _____

Have you had any surgical treatment? ☐ no ☐ yes

Do you use any assistive devices (cane, walker, crutches, etc): ☐ no ☐ yes _____

Occupation: _____

Hobbies: _____

Name:
Chart:
Date:

Kennedy-White Orthopaedic Center
6050 CATTLERIDGE BLVD. #201 SARASOTA, FLORIDA 34232
(941) 365-0655

Medical Supply Waiver

Any medical supplies not covered by your insurance company will be billed to you and will be your responsibility to pay at the time of service.

Any medical supplies that are subject to coinsurance payment will be billed to you after notification from your insurance company indicating your responsibility.

All payments are due within 30 days of our billing statement.

If you have any questions or concerns, please do not hesitate to contact our Business Office at 365-0655.

RETURN POLICY: *Kennedy-White Orthopaedic Center cannot, by law, accept a return on any product that has been worn, even if only for a short period of time. Our company cannot accept a return on any "custom-made" braces as they are manufactured specifically for that patient and therefore cannot be returned to the manufacturer. We will, however, assist in any problems (i.e. fitting, discomfort, etc.) which may occur with the product.*

Print Patient/Guardian Name

Signature

Date

Outstanding Balances

Any patients having an outstanding balance that is referred to a collection agency will not be able to make an appointment until the balance is paid in full. Delinquent accounts referred to a collection agency will be subject to an additional $50 charge.

Print Patient/Guardian Name

Signature

Date

Name:
Chart:
Date:

We are required to ask the questions below by the United States Government

☐ ***If you have already completed this form please check this box and sign and date below.**

1. Preferred Language

☐ I decline to answer

☐ English
☐ Spanish
☐ French
☐ Other_____

2. Race

☐ I decline to answer

☐ American Indian ☐ Asian ☐ Black
☐ Native Hawaiian ☐ White

3. Ethnicity

☐ I decline to answer

☐ Hispanic Origin ☐ Non-Hispanic Origin

4. Smoking Status

☐ I decline to answer

☐ Current Every Day Smoker Start Date:_____ Packs Per Day: _____
☐ Current Some Day Smoker Start Date:_____ Packs Per Day: _____
☐ Smoker, Current Status Unknown Start Date:_____ Packs Per Day: _____
☐ Former Smoker Start Date:_____ Quit Date: _____
☐ Never Smoker

5. E-mail Address _____ ☐ I decline to answer

_____ _____
Signature Date

Name:
Chart:
Date:

Kennedy-White Orthopaedic Center
HIPAA Notice of Privacy Practices

Acknowledgement of Receipt

I, _____, have been given a copy of the Kennedy-White
(Printed patient name)
Orthopaedic Center Summary Notice of Privacy Practices.

_____ _____
Patient Signature Date

Authorization For Family, Friends, Or Advisors To Receive Information About Your Medical *Condition* Or The *Status* Of Your Bill.

I authorize the following individual(s) to receive written and/or oral communications about my medical condition, care, appointments, and the status of my bill. I understand that they will need to be able to provide the last four digits of my social security number for oral communication. If they should come to pick up a prescription or to discuss my care or the status of my bill, they will need to bring a photo id.

Authorized Individual(s) Please print name(s)

_____ _____

_____ _____

_____ _____

_____ _____
Patient Signature Date