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 ☐ CLAIM # ☐ REFERRAL		POLICY #	☐ AUTHORIZATION ☐ CLAIM # ☐ REFERRAL	
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

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.

SIGNATURE (parent if minor) DATE

MEDICARE AUTHORIZATION TO RELEASE INFORMATION AND MEDICARE ASSIGNMENT

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

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:

PAIN DRAWING

(to be completed at each office visit)

NAME _____ DATE _____

☐ Right Handed Weight _____

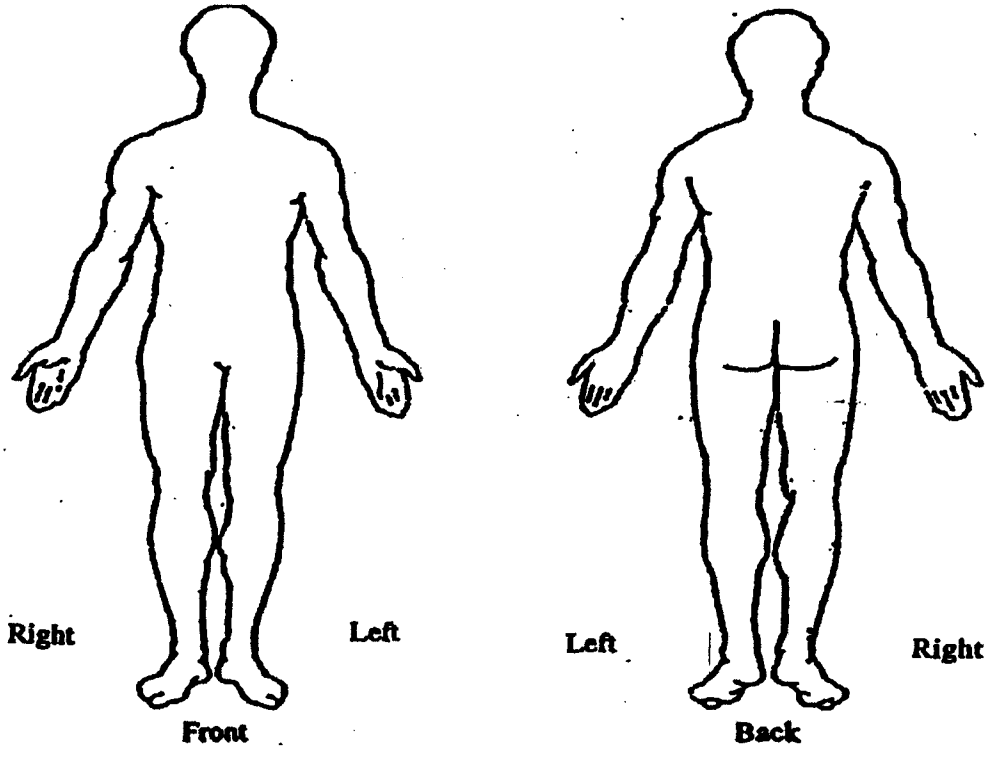
☐ Left Handed Height _____

Where is your pain now?

Mark the areas on the body where you feel the sensations described below using the appropriate symbol.

Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

Numbness	Aching	Pins & Needles	Burning	Stabbing
▲▲▲	= = =	o o o	xxx	///



Mark your current pain level below:

0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Pain Worst Possible Pain

IS YOUR CURRENT TREATMENT PLAN HELPING? (Circle) YES NO

HOW IS YOUR PAIN CHANGING? (Circle) BETTER WORSE UNCHANGED

HOW DO YOU SLEEP? (Circle) EXCELLENT GOOD FAIR POOR

HOW IS YOUR SOCIAL LIFE? (Circle) EXCELLENT GOOD FAIR POOR

ARE YOU DEPRESSED? (Circle) NEVER SOMETIMES ALWAYS

HOW IS YOUR BLADDER FUNCTION? (Circle) NORMAL CHANGED

HOW IS YOUR BOWEL FUNCTION? (Circle) NORMAL CONSTIPATION DIARRHEA

Name:
Chart:
Date:

NEW PATIENT PAIN QUESTIONNAIRE

WHEN (roughly what date) DID YOUR PRESENT PAIN START? _____

HAVE YOU EVER HAD SIMILAR PAIN BEFORE? If yes, when _____

HOW DID YOUR PAIN START? (check appropriate box)

- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ Twisting
- ☐ Bending
- ☐ Pulling
- ☐ Injured at work
- ☐ Injured in auto accident
- ☐ Injured during sports
- ☐ No apparent cause

HOW OFTEN DO YOU FEEL PAIN? (once a day, constant, weekly, etc...) _____

HOW LONG DOES THE PAIN LAST? (a minute, all day, a week, etc...) _____

WHAT ACTIVITIES MAKE THE PAIN WORSE?

- ☐ Exercise (during)
- ☐ Exercise (after)
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Coughing/sneezing
- ☐ Bending forward
- ☐ Bending backward

Other _____

WHAT REDUCES THE PAIN?

- ☐ Lying down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Manipulation
- ☐ Physical Therapy
- ☐ Pain pills
- ☐ Injections for pain
- ☐ Muscle relaxant pills
- ☐ Aspirin/anti-inflammatories
- ☐ Nothing
- ☐ Exercise

Other _____

DOES THE PAIN RADIATE? If so, where _____

ARE THERE ANY OTHER SYMPTOMS? (list) _____

WHAT TESTS HAVE YOU HAD?

	Yes	No	Date
Diagnostic x-rays	☐	☐	_____
CT Scan	☐	☐	_____
MRI	☐	☐	_____
Myelogram (x-ray with dye injection)	☐	☐	_____
Electromyography (EMG)	☐	☐	_____
Arthrogram or sonogram	☐	☐	_____

WHAT TREATMENT HAVE YOU TRIED?

- ☐ Physical Therapy
- ☐ Braces
- ☐ Heating pad
- ☐ Ice
- ☐ Manipulation
- ☐ TENS
- ☐ Traction
- ☐ Injections
- ☐ Surgery
- ☐ Home exercises
- ☐ Other: _____
- ☐ Medications (please list any that you have tried) _____

(Please answer the following questions:)

Do you need assistance with your basic daily routine? (circle) YES NO (circle items): eating, dressing, bathing, grooming, housework

Do you exercise? (circle) YES NO If yes, what do you do and how often? _____

Do you use an assistive device (cane, walker, crutch, etc...)? _____

What are your hobbies? _____

What is your occupation? _____

Name:
Chart:
Date:

The words below refer to types of pain. Some of these words may help describe your pain experience. Choose words that best describe your pain and circle them. Omit groups (and words) that do not describe your pain.

flickering				
quivering	pricking	pinching	dull	
pulsing	boring	pressing	sore	
throbbing	drilling	gnawing	hurting	
beating	stabbing	cramping	aching	
pounding	lancinating	crushing	heavy	

jumping	sharp	tugging	fearful
flashing	cutting	pulling	frightful
shooting	lacerating	wrenching	terrifying

hot	tingling	tender	spreading	
burning	itchy	taut	radiating	
scalding	smarting	rasping	penetrating	
searing	stinging	splitting	piercing	

tiring	sickening	wretched	cool
exhausting	suffocating	blinding	cold
			freezing

punishing	annoying	tight	nagging	
grueling	troublesome	numb	nauseating	
cruel	miserable	drawing	agonizing	
vicious	intense	squeezing	dreadful	
killing	unbearable	tearing	torturing	

continuous	rhythmic	brief	
steady	periodic	momentary	
constant	intermittent	transient	

Rate your pain intensity as it changes during the times of the day listed below. Pick the word that describes your pain best then write the number of that word on the line to complete each statement. Do the same to rate other pains from your past.

0	1	2	3	4	5
None	Mild	Discomforting	Distressing	Horrible	Excruciating

My pain in the morning is: _____
My pain in the mid-day is: _____
My pain late afternoon is: _____
My pain in the evening is: _____
My pain right now is: _____

My pain at its least is: _____
My pain at its worst is: _____
The worst headache I ever had was: _____
The worst toothache I ever had was: _____
The worst stomachache I ever had was: _____

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

FC29

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