

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		PHONE		<input type="checkbox"/> HMO COPAY\$		INSURANCE COMPANY		PHONE		<input type="checkbox"/> HMO COPAY\$					
WORKERS COMPENSATION				<input type="checkbox"/> PPO COPAY\$						<input type="checkbox"/> PPO COPAY\$					
INS. CLAIMS MAIL TO:						INS. CLAIMS MAIL TO:									
STREET						STREET									
CITY/STATE/ZIP				ADJUSTER NAME				CITY/STATE/ZIP				ADJUSTER NAME			
POLICY #		<input type="checkbox"/> AUTHORIZATION		<input type="checkbox"/> CLAIM #		POLICY #		<input type="checkbox"/> AUTHORIZATION		<input type="checkbox"/> CLAIM #					
		<input type="checkbox"/> REFERRAL						<input type="checkbox"/> 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						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 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 TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.						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	PREVIOUS SURGERIES	REVIEW OF SYSTEMS																																																																																																																																																																																																																																																									
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<input type="checkbox"/>	<input type="checkbox"/>	asthma/ emphysema/ COPD																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	TB (tuberculosis)																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	pulmonary embolus																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	blood clot in leg (DVT)																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	neuropathy																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	thyroid disease																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	HIV (AIDS)																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	kidney failure																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	stomach ulcer																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	gastric bleeding																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	reflux (GERD)																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	hepatitis																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	liver disease																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	CANCER, list type(s)																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	_____																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	seizure disorder (epilepsy)																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	multiple sclerosis																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	dementia																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	depression																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	bipolar disorder																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	anxiety disorder																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	mental illness																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____																																																																																																																																																																																																																																																									
Y	N																																																																																																																																																																																																																																																										
<input type="checkbox"/>	<input type="checkbox"/>	prior problems with anesthesia																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	gallbladder																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	appendix																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	prostate																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	hysterectomy/ovaries																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	heart stents																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	heart bypass																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	heart valve surgery																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	spine surgery																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	hip surgery																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	knee surgery																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	shoulder surgery																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	hand surgery																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	other surgeries (list):																																																																																																																																																																																																																																																									

Y	N																																																																																																																																																																																																																																																										
<input type="checkbox"/>	<input type="checkbox"/>	chest pain																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	night sweats/fever																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	weight loss (unintentional)																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	heartburn caused by medicine																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	blurred vision																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	blood in urine																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	burning on urination																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	skin rash																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	loss of hearing																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	easy bleeding/bruising																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	seizures/convulsions																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	loss of memory																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	claustrophobia																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	dizziness																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	nausea/vomiting																																																																																																																																																																																																																																																									
<input type="checkbox"/>	<input type="checkbox"/>	numbness hands/feet																																																																																																																																																																																																																																																									
<p>SOCIAL HISTORY: Married <input type="checkbox"/> Single <input type="checkbox"/> Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widow/Widower <input type="checkbox"/></p> <p>Number of Children: _____ Presently living alone? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>With which hand do you write: right <input type="checkbox"/> left <input type="checkbox"/> both <input type="checkbox"/></p> <p>Do you currently use a cane or walker? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do you smoke? Never <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If no, when did you quit: _____ If yes, how many packs per day: _____ If yes, how many years: _____</p> <p>Alcohol: Never <input type="checkbox"/> Never, but I used to <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate-to-heavy use <input type="checkbox"/> # of drinks per day _____ Prior Alcohol Abuse Problem <input type="checkbox"/></p> <p>Drug Problem: Never <input type="checkbox"/> Present <input type="checkbox"/> Past Problem <input type="checkbox"/></p>																																																																																																																																																																																																																																																											

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