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

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:

CLINICAL HISTORY FOR SPINAL DISORDERS

Describe problem you are being seen for today. ____

____

When did your back or neck pain first begin? ____________________

When did your arm or leg pain first begin? ____________________

Did your pain start __ gradually or __ suddenly. Any injury?__ Yes __ No__

If yes, describe the injury ____

Which treatments have you had? __therapy exercises __modalities (heat, ultrasound, electrical stimulation) __anti-inflammatories (Motrin, Advil, etc..) __cortisone shots.

List treatments that have helped: ____

List treatments that have made it worse: ____

What would you like to do that you cannot do because of your pain? ____________________

____

Do you have buttock or leg pain while walking? __ Yes __ No.

How long can you walk without pain? ____

What time of day is your pain worse __ Morning __ Later in day __ Middle of night.

Have you had recent __ Fevers __ Chills__ Night sweats __ Weight loss.

My pain is: (check appropriate column)

Better	Worse	No different	
______	______	______	With coughing/sneezing/straining
______	______	______	With sitting
______	______	______	With bending forward to brush teeth or pushing grocery cart
______	______	______	With lying down
______	______	______	With standing
______	______	______	With walking
______	______	______	With sitting down or leaning forward after walking

	Yes	No
Do you feel unsteady with your gait?	____	____
Do you have difficulty with buttoning a shirt, combing hair?	____	____
Do you drop things out of your hand?	____	____
Do you have headaches and or vision problems?	____	____
Have you had any recent changes in bowel or bladder habits?	____	____

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Name:
Chart:
Date:

KENNEDY - WHITE ORTHOPAEDIC CENTER

Patient Name: ______________________ TODAY'S DATE: __________

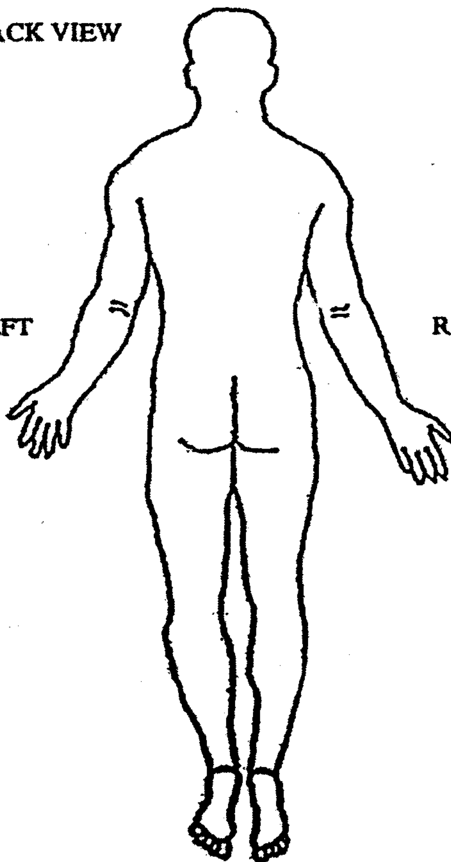
In percentage, how much of the pain is in your back/neck and how much in your legs/arms?

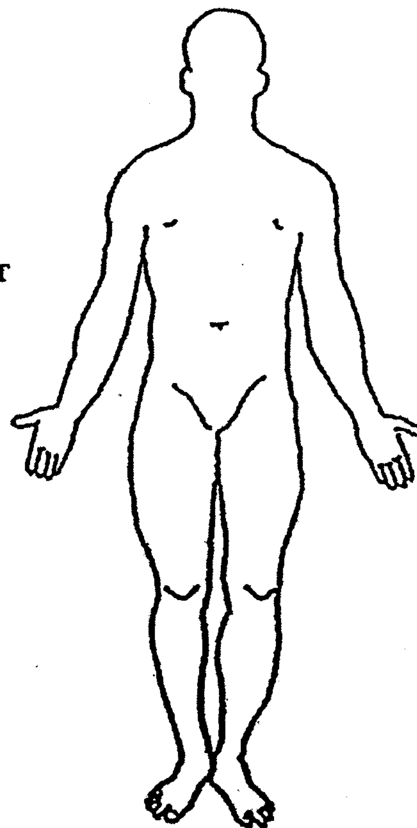
The total should add up to 100%

	________	% of the pain is in my back/neck.
+	________	% of the pain is in my legs/arms
=	100%	

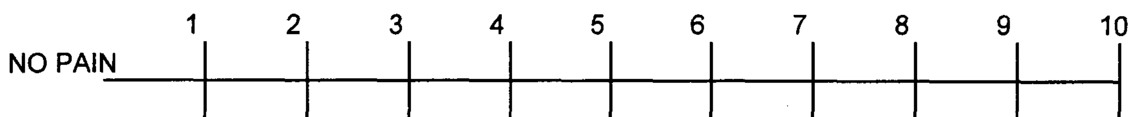
On the following diagram, mark the areas on your body where you feel the following sensations.

PAIN	NUMBNESS TINGLING PINS & NEEDLES
XXXX	OOOO





PLEASE USE THE SCALE BELOW TO INDICATE THE LEVEL OF PAIN



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