PLEASE BRING WITH YOU TO YOUR APPOINTMENT

DEMOGRAPHICS:

NAME AND ADDRESS

PATIENT NAME			PRIMARY LANGUAGE		
ADDRESS	CITY, STATE		ZIP CODE		
HOME PHONE #	WORK PHONE #	CELL PHONE #	EMAIL ADDRESS		
DATE OF BIRTH	AGE	GENDER ☐ MALE ☐ FEMALE	MARITAL ☐ MARRIED ☐ WIDOWED	STATUS ☐ SINGLE ☐ DIVORCED	SSN#

FILL OUT RESPONSIBLE PARTY INFO, IF PATIENT IS UNDER 18 OR HAS LEGAL GUARDIAN

LAST NAME	FIRST NAME		MIDDLE INITIAL/NAME
ADDRESS	CITY/STATE		ZIP CODE
HOME PHONE #	WORK PHONE #	CELL PHONE #	EMAIL ADDRESS

EMPLOYMENT INFORMATION

☐ EMPLOYED	☐ UNEMPLOYED	☐ STUDENT	☐ RETIRED	☐ DISABLED
EMPLOYER	OCCUPATION/TITLE		☐ FULL DUTY ☐ LIGHT DUTY	
EMPLOYER ADDRESS			EMPLOYER PHONE #	

INSURANCE/BILLING INFORMATION

☐ MEDICAL INSURANCE	☐ AUTO INSURANCE	☐ WORKERS COMP	☐ SELF PAY	
PRIMARY INSURANCE	TYPE (PPO, HMO,ETC.)	POLICY HOLDER	RELATION TO PATIENT	INS PHONE #
GROUP NAME (EMPLOYER)	POLICY #	GROUP #	SUBSCRIBER BIRTHDATE	SUBSCRIBER SOC SEC #
SECONDARY INSURANCE	TYPE (PPO, HMO,ETC.)	POLICY HOLDER	RELATION TO PATIENT	INS PHONE #
GROUP NAME (EMPLOYER)	POLICY #	GROUP #	SUBSCRIBER BIRTHDATE	SUBSCRIBER SOC SEC #

WORKERS COMP OR AUTO ACCIDENT INFORMATION

Is your complaint Accident Related? ☐ NO ☐ YES If yes, please fill out the Accident Information

☐ AUTO ☐ WORK COMP ☐ LIABILITY INJURY DATE_____	STATE	BODY PART(S) PROBLEMS	CLAIM #	
ADJUSTER/CASE MANAGER	COMPANY	PHONE #	FAX #	

EMERGENCY CONTACT (SOMEONE WITH A DIFFERENT PHONE # THAN YOURS

NAME	RELATIONSHIP	PHONE #

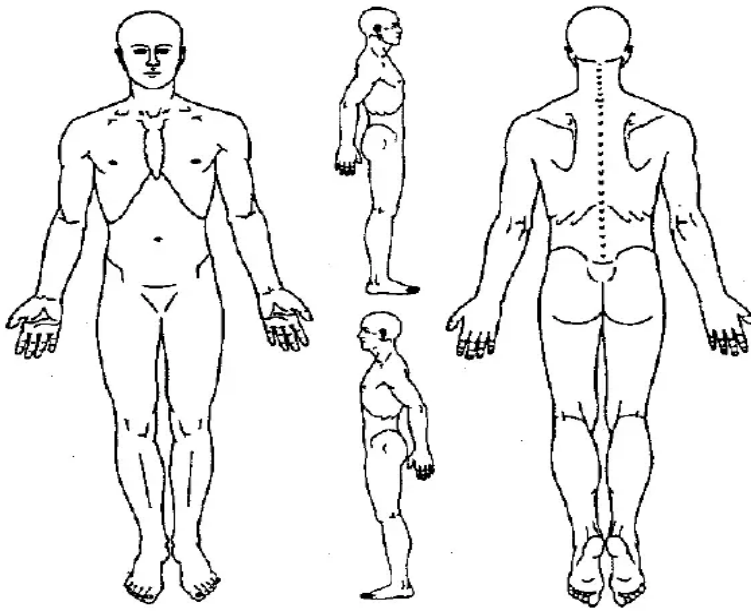
PATIENT SIGNATURE: _____

DATE	NAME	DOB	AGE	GENDER ☐ MALE ☐ FEMALE

What is your main complaint?

Mark problem areas of pain

X X X = Aching	**- - - = Burning**	*** * * * = Pins & Needles**
> > = Shooting	**/ / / = Stabbing**	**0 0 0 0 = Throbbing**



RT LT LT RT

PAIN SCALE

Rate your pain on the scale from 1-10 with an X

NO PAIN	MINIMAL	MODERATE	INTENSE	EMERGENCY
0	1-3	4-6	7-9	10
1 2	3 4	5 6	7 8	9 10

SYMPTOMS
Activity Level is – **Please Circle** Unchanged Reduced Diminished Unable to perform manual labor? Unable to perform daily household chores?
How many hours a day do you experience pain? **CIRCLE:** Constant Intermittent Occasional
How many days a week do you experience pain? **CIRCLE:** Constant Intermittent Occasional
What Activities are most affected by your pain?
What Activity makes your pain better?
What Activity makes your pain worse?
Do you have severe nighttime pain?
Do you wake up in the middle of the night because of pain?
Symptoms started

☐	Difficulty Walking	☐	Radiation/Shooting Pain
☐	Buckling	☐	Stiffness
☐	Grating	☐	Swelling
☐	Locking	☐	Tingling
☐	Numbness	☐	Weakness
☐	Pain	☐	
☐	Other		
☐	**Similar Past Injury/Problem**	☐ **YES**	☐ **NO**

If Yes, What

PREVIOUS EVALUATIONS

PLACE		TEST	
☐	Emergency Room	☐	CT Scan
☐	Family Dr.	☐	MRI
☐	Orthopaedic Dr.	☐	EMG Nerve Cond
☐	Neurologist	☐	Bone Scan
☐	Walk-In Clinic	☐	Disco Gram
☐	Workers Comp Clinic	☐	Xray
OTHER ☐		☐	Myelogram
Available for today's Appt		☐ Report	☐ Films

TREATMENT RECEIVED

☐	Acupuncture	☐	Physical Therapy
☐	Arthroscopy	☐	Psych Support
☐	Back to Schl Edu	☐	Surgery
☐	Biofeedback	☐	TENS Unit
☐	Braces/Support	☐	Traction
☐	Chiropractic	☐	Work Hardening
☐	Hospitalizations	☐	
☐	Injections	☐	PAIN ☐ ANTI-INFLAMATORY
☐	Medication	☐	PAIN ☐ ANTI-INFLAMATORY

DATE		NAME	DOB	AGE	GENDER ☐M ☐F	☐ RT HANDED ☐ LT HANDED

Family History	Father	Mother	Sibling
Bleeding Problems			
Diabetes			
Heart Disease			
Hypertension			
Stroke			
Rheumatoid Arthritis			
Cancer			

☐Yes☐No Can you take Aspirin?

☐Yes☐No Have you had a Tetanus shot?

If Yes, When_____

SOCIAL HISTORY

Marital Status

☐Single ☐ Married ☐ Divorced ☐Separated ☐Widow(er)

Smoke Cigarettes

☐Yes ☐No

If Yes, Packs per Day_____

Drink Alcohol

☐Yes☐No

If Yes, How Much Per Day_____

Substance Abuse

Do you have a history of Substance Abuse?

☐Yes ☐No

Occupation

What is your job occupation?

Could you be Pregnant?

☐Yes ☐No?

MEDICAL / SURGICAL HISTORY

Please Mark the boxes in this column with

Anemia		
Arthritis		
Asthma		
Bleeding Disorder		
Cancer		
Depression		
Diabetes		
Gout		
Heart Disease		
High Blood Pressure		
Hypercholesterolemia		
Kidney Problems		
Liver Problems		
Lung Disease		
Phlebitis/Blood Clots		
Seizures		
Serious Injuries		
Stomach Ulcers		
Stroke		
Thyroid Trouble		
Tuberculosis		
Urinary Problems		

OTHER			

SURGICAL	YES	NO	YEAR	HOSPITALIZED
Back				
Joint				
Hip				
OTHER				
OTHER				

SURGERY COMPLICATIONS	YES	NO
Wound Infections		

REVIEW OF SYSTEMS

	YES	NO
Chills		
Eyes		
Irritation		
Vision Change		
ENT		
Difficulty Hearings		
Sinus Problems		
Nose Problems		
Sore Throat		
Cardiovascular		
Chest Pain		
Palpitations		
Respiratory		
Wheezing		
Shortness of Breath		
Coughing		
GI		
Constipation		
Diarrhea		
Vomiting		
Nausea		
GU		
Increased Urinary Frequency		
Difficulty Urinating		
Musculoskeletal		
Join Pains		
Swelling in the Extremities		
Muscle Aches		
Skin		
Changes in Skin Color		
Rashes		
Neuro		
Weakness		
Numbness		
Psych		
Depression/Anxiety/Moody		
Sleep Disturbances		
Memory Loss		
Endocrine		
Fatigue		
Hematologic/ Lymphatic		
Easy Bruising		
Excessive Bleeding		
Allergic/ Immunologic		
Runny Nose		
Hives		
Itching		

Baylis and Brown Orthopedics
350 NW 84th Avenue, Suite 312
Plantation, FL 33324
P: 954-476-8800; F: 954-476-1362

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Authorization for Release of Medical Records/ Payment Authorization/ Practice Policies

Name: _____ Date of Birth: _____/_____/_____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse_____

☐ Child(ren)_____

☐ Not to be released to anyone

☐ Physician Name/ Office: _____

Check information requested and how to be sent. X-Rays incur a cost of $10.00.

_____Entire Record _____X-Ray _____ E-mail _____ Fax _____ US Mail

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell number

If unable to reach me: ☐ you may leave a detailed message ☐ please leave a message asking me to return your call.

I understand that I have a right to evoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released by this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with authorization. This authorization is valid for one year from the date of signature if not specified.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for subsequent unauthorized disclosure and the information may not be protected by federal confidentiality rules. I also understand that although the practice makes its best efforts, the transmission of information via email or text between the practice and myself may not be encrypted and secure. If I have any questions about disclosure of my health information, I can contact Medical Records Department at (954) 476-8800.

Assignment of Insurance Benefits: I hereby authorize payment directly to Baylis & Brown Orthopedics ("BABO") and assign to them any and all rights and benefits that I or the patient may have under and policy of insurance including medical, automobile, personal injury protection, workers compensation, or any other coverage and further direct any such insurance company to make payment of benefits directly. I understand that I am financially responsible to practice for charges not covered by this assignment.

Consent to Medical and Surgical Treatment: The undersigned hereby consents to all medical care and services, surgical treatments. Examinations, tests and procedures, including but not limited to X-Ray examination, laboratory and diagnostic procedures and tests, anesthesia, which a physician, their employees, nurses, associates, assistants, or designees may deem advisable to the undersigned patient during his treatment.

Payment Guarantee: The understand patient and guarantor, if any, hereby agree to BABO charges to BABO in accordance with the regular rates and terms of BABO and agree to pay for any charges not covered by any third-party payer. The medical practice files insurance as a courtesy to the patient, but the patient is ultimately responsible for the payment of the total incurred charges. The undersigned agrees that if the account is turned over to a collection agency or attorney, that the undersigned patient shall be obligated to pay outstanding balance plus all court, collection, and attorney costs. The undersigned agrees that any overpayment collected on this account may be applied to any delinquent account for which the undersigned patient is legally responsible.

Referral Policy: The purpose of this notice is to inform you of our office policy regarding referrals. If your plan requires that you obtain a referral for specialist services, it is your responsibility to do so. We do not contact the primary care physician (PCP) for referrals. If you present to the office without a referral, you have the option of paying out of pocket or rescheduling your appointment until you have obtained a referral.
For your convenience, we will accept faxed referrals. However, it is the patient/parent/guardian's responsibility to ensure that the referral is received in the office prior to the appointment. Please feel free to call our office to verify that the referral has been received before arriving to our office if the referral is being faxed. We will not be responsible for referrals that are expired or otherwise invalid. Please request a copy of your referral if one has not been provided to you to enable you to track when a referral is needed. Please advise our office immediately of any changes in your insurance policy as this may void any referrals on file and may result in unnecessary out of pocket expenses to you. If you need assistance in understanding your insurance policy, please see one of our administrative staff members or management and we will gladly assist you.

Controlled Substances Policy: I am responsible for my controlled substances and all prescription medications. If the prescription or medication is lost, misplaced or stolen or I use it sooner than prescribed, I understand that it will not be replaced. I will not request nor accept controlled substance medication from any other physician or individual while I am receiving such medications from BABO. The exception would be if I were hospitalized and under the care of another physician. I understand that if I violate any of the above conditions, my relationship with BABO may be terminated. I understand that I may be reported to the Drug Enforcement Authorities, other physicians and local medical facilities.

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____