Please review and complete the information below to the best of your ability. Print clearly in black or blue ink. Bring this completed packet, your photo ID, and your insurance card(s) to your first appointment.

PATIENT INFORMATION

Please print

Last Name | First Name | Middle Name

Street Address | Apartment / Unit

City | State | ZIP Code

Date of Birth (mm/dd/yyyy) | Home Phone | Mobile Phone | Work Phone

Email Address (used to register for the patient portal) | Marital Status

Sex: ☐ Male ☐ Female ☐ Prefer not to answer

Preferred contact method: ☐ Home Phone ☐ Mobile Phone ☐ Work Phone ☐ Patient Portal ☐ Email

Social Security Number (optional — may be provided securely at the office if needed)

Requested by government mandate — you may decline to answer any item below.

Preferred Language | Race | Ethnicity

Patient Referred By | Primary Care Provider

GUARANTOR INFORMATION

Person to whom statements are sent

Guarantor Name | Relationship to Patient | Date of Birth

Street Address | City | State | ZIP Code

Phone | Employer (if applicable)

EMERGENCY CONTACT

Name | Relationship to Patient | Phone | Mobile Phone

EMPLOYER INFORMATION

Employer Name | Occupation | Phone

Employer Address | City | State | ZIP Code

PREFERRED PHARMACY

Pharmacy Name | Cross Streets / Location | Phone

PRIMARY INSURANCE

Please present your card at check-in

Insurance Plan Name | Patient's Relationship to Policy Holder

Policy Holder Last Name | First Name | Middle Name

Policy Holder Address | City | State | ZIP Code

Policy Holder Date of Birth | Policy Holder Employer Name

Policy holder sex: ☐ Male ☐ Female ☐ Prefer not to answer

SECONDARY INSURANCE

Complete only if you have secondary coverage

Insurance Plan Name | Patient's Relationship to Policy Holder

Policy Holder Last Name | First Name | Middle Name

Policy Holder Address | City | State | ZIP Code

Policy Holder Date of Birth | Policy Holder Employer Name

Policy holder sex: ☐ Male ☐ Female ☐ Prefer not to answer

ATTESTATION

To the best of my knowledge, the information provided above is complete and accurate. I will notify Wellington Orthopedic Institute of any changes.

Signature of Patient and/or Guardian | Relationship to Patient (if guardian) | Date

CHIEF COMPLAINT

Side affected: ☐ Right ☐ Left ☐ Both ☐ Not applicable

Part of the body / reason for being seen today

Height _____ Weight _____ Preferred Pharmacy _____

HISTORY OF PRESENT ILLNESS

Please describe how your problem started. Answer each question below.

☐ Y ☐ N No injury (symptoms began without a specific injury)
If so, was the onset: ☐ Gradual ☐ Sudden
Date of onset: _____

☐ Y ☐ N Injury
If so, was the injury related to: ☐ Accident ☐ Sport ☐ Other ☐ Unsure
Date of injury: _____

☐ Y ☐ N Work-related injury
If so, was the injury caused by: ☐ Lift ☐ Twist ☐ Fall ☐ Bend ☐ Pull ☐ Reach ☐ Repetitive activity
Date of injury: _____

☐ Y ☐ N Auto accident
Date of accident: _____

Description of injury, accident, or problem:

_____

_____

☐ Y ☐ N Have you ever had a problem like this before?
If yes, please explain: _____

☐ Y ☐ N Have you been seen in the emergency room or urgent care for this problem?
If yes, where: _____

☐ Y ☐ N Have you had any tests or scans performed for this problem?
If yes, select all that apply: ☐ X-rays ☐ MRI ☐ CT scan ☐ Bone scan ☐ Nerve test (EMG/NCV) ☐ Other

☐ Y ☐ N Have you received any treatment for this problem?
If yes, please explain: _____

PAIN ASSESSMENT

On a scale of 0 to 10 (10 being the worst), how severe is your pain?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Please describe the pain: ☐ Constant ☐ Intermittent (comes and goes) ☐ Wakes you up

☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ No pain

ASSOCIATED SYMPTOMS

Please note if you experience any of the following: ☐ Swelling ☐ Bruising ☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of control of bowel or bladder ☐ Locking or catching ☐ Giving way ☐ Pain ☐ Stiffness

Other: _____

Since the problem started, is it: ☐ Getting better ☐ Worse ☐ Unchanged

AGGRAVATING & RELIEVING FACTORS

What makes your symptoms worse: ☐ Standing ☐ Walking ☐ Lifting ☐ Twisting ☐ Bending ☐ Stairs ☐ Exercise ☐ Squatting ☐ Kneeling ☐ Sitting ☐ Coughing ☐ Sneezing ☐ Lying in bed

Other: _____

What makes your symptoms better: ☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ Medication ☐ Bracing or support ☐ Physical therapy ☐ Nothing helps

Other: _____

ADDITIONAL DETAILS

Anything else you would like the provider to know about your symptoms, prior imaging, or previous care:

_____

_____

_____

_____

Before your visit

Bring a photo ID, your insurance card(s), a list of your current medications, and any imaging reports or discs related to this problem. Arrive 15 minutes early so our team can review this packet with you. If you have questions while completing these forms, call the office at 561-670-2010.

PAST MEDICAL HISTORY

Please indicate all that apply

Please indicate any of the following diagnoses or treatments you have received.

Cardiovascular
☐ Y ☐ N Cardiac disease or heart problem
☐ Y ☐ N Deep vein thrombosis
☐ Y ☐ N Heart surgery
☐ Y ☐ N Pacemaker or AICD
☐ Y ☐ N Hypertension
☐ Y ☐ N Lymphedema
☐ Y ☐ N Atrial fibrillation
Other: _____

Dermatologic (skin)
☐ Y ☐ N Herpes
☐ Y ☐ N Skin cancer
Other: _____

Endocrine
☐ Y ☐ N Diabetes (type: _____)
☐ Y ☐ N Hyperthyroidism
☐ Y ☐ N Hypothyroidism
Other: _____

Gastrointestinal
☐ Y ☐ N Gastritis or GI bleed
☐ Y ☐ N Ulcer
☐ Y ☐ N Crohn's disease
☐ Y ☐ N Ulcerative colitis
Other: _____

Genitourinary
☐ Y ☐ N Dialysis
☐ Y ☐ N Kidney stones
☐ Y ☐ N Renal insufficiency
Other: _____

HEENT (head, eyes, ears, nose, throat)
☐ Y ☐ N Glaucoma
☐ Y ☐ N Hearing loss
Other: _____

Hematologic (blood)
☐ Y ☐ N Anemia
☐ Y ☐ N Bleeding tendencies
☐ Y ☐ N Blood clotting abnormalities
☐ Y ☐ N Hepatitis (type: _____)
Other: _____

Immunologic
☐ Y ☐ N Cancer (type: _____)
☐ Y ☐ N Chemotherapy
☐ Y ☐ N Radiation therapy
☐ Y ☐ N HIV / AIDS
☐ Y ☐ N Systemic lupus
Other: _____

Musculoskeletal
☐ Y ☐ N Fibromyalgia
☐ Y ☐ N Gout
☐ Y ☐ N Osteoarthritis
☐ Y ☐ N Rheumatoid arthritis
Other: _____

Neurological
☐ Y ☐ N Seizure disorder
☐ Y ☐ N Stroke
☐ Y ☐ N Alzheimer's disease
☐ Y ☐ N Parkinson's disease
☐ Y ☐ N Neuropathy
Other: _____

Psychiatric History
☐ Y ☐ N Alcohol abuse
☐ Y ☐ N Drug abuse
☐ Y ☐ N Anxiety disorder
☐ Y ☐ N Depression
Other: _____

Respiratory
☐ Y ☐ N Asthma
☐ Y ☐ N COPD (chronic lung disease)
☐ Y ☐ N Pulmonary embolism
☐ Y ☐ N Sleep apnea
Other: _____

Pediatric patients only — immunizations: ☐ Current ☐ Not current ☐ Exempt

☐ Y ☐ N Are you pregnant or is there any chance you may be pregnant?

Please list and explain any other conditions here:

_____

PAST HOSPITALIZATIONS & SURGICAL HISTORY

Please list all previous hospitalizations, surgeries, and procedures, including dates:

MEDICATIONS

Please list all current medications and dosages, including over-the-counter medicines, vitamins, and supplements.

ALLERGIES

Please list all known drug allergies and the reaction each one causes. Write "None known" if you have none.

SOCIAL HISTORY

☐ Y ☐ N Do you smoke or use tobacco products?

If so, how much: _____

If you quit, how long ago: _____

☐ Y ☐ N Do you drink alcohol?

If so, how much: ☐ Social ☐ Moderate ☐ Heavy

Relationship status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Pediatric Patients Only Patients 17 years old and under

Grade in school: _____

Who lives in the home? ☐ Mother ☐ Father ☐ Sister(s) ☐ Brother(s) ☐ Grandparent(s)

Other: _____

FAMILY HISTORY

Has a parent, sibling, or child been diagnosed with any of the following?

☐ Y ☐ N Cancer
☐ Y ☐ N Diabetes
☐ Y ☐ N Heart attack
☐ Y ☐ N Heart disease (other)
☐ Y ☐ N High blood pressure
☐ Y ☐ N Stroke

FINANCIAL POLICY

Thank you for choosing Wellington Orthopedic Institute, LLC as your health care provider. We are committed to your health and well-being and want your care and treatment to be successful. Please understand that payment of your account is considered an integral part of your treatment.

We ask that all responsible parties read and sign this policy before seeing the physician. This policy is offered to develop and sustain a continued professional and pleasant relationship. Our billing department is available to discuss our fees and this policy with you.

We are a specialist health care provider; therefore, specialist co-payments and deductibles are due at the time of service.

Our providers accept most — but not all — insurance plans. Please check with our staff if you are unsure whether we accept your plan. If your insurance plan is one we do not accept, you may be seen and treated by providers at Wellington Orthopedic Institute, LLC as out-of-network. You may be responsible for the full charges of the services rendered, or you may be required to pay out-of-network cost sharing under your health plan. Please see the out-of-network consent and estimated cost of services.

Uninsured (self-pay): payment in full is expected at the time of service unless arrangements have been made with our billing department before services are rendered.

We accept cash, check, American Express, Visa, Mastercard, Discover, and CareCredit.

Please read the following carefully:

1. We will ask for your insurance card during your visit. Please be prepared to present it at check-in.
2. Payments for all services — including unpaid balances, deductibles, co-payments, and other non-covered services as set by your insurance carrier — are due at the time of service. Unpaid balances may be subject to collection placement and collection fees. A $25 service fee will be assessed for returned checks, regardless of the reason.
3. Your insurance policy is a predetermined agreement between you, your employer, and the insurance company. We are not a party to that agreement; our relationship is with you, not your insurance company. As your provider, we will supply information to facilitate claim processing. Please understand that we may not know whether your insurance will cover your service(s) until the claim has been submitted. Although we may estimate what your insurance company will pay, the insurance company makes the final determination of your eligibility and benefits. Any laboratory test that requires an outside lab to perform will be billed by that company.
4. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, then after such default and upon referral to a collection agency or attorney by Wellington Orthopedic Institute, LLC, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

FINANCIAL AGREEMENT

I have read, understand, and agree to this financial policy. In the event of non-payment by my insurance carrier for any reason, I understand that I am responsible for payment of the balance owed, inclusive of all court costs and attorney fees of 30%. I authorize the release of any medical or other information necessary to process medical claims. I authorize payment of medical benefits to Wellington Orthopedic Institute, LLC.

Patient Printed Name _____ Date _____

Signature of Patient and/or Guardian _____ Relationship to Patient _____ Witness (Staff) _____

HIPAA NOTICE OF PRIVACY PRACTICES

Written acknowledgment form

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose medical information about you. As stated in the notice, the terms of our notice may change. If we change our notice, you may request a revised copy.

I, _____ (please print patient name),

have been provided access to a copy of Wellington Orthopedic Institute, LLC's Notice of Privacy Practices for review.

This acknowledgment form will remain in effect until revoked by me in writing. I understand that I may ask questions of the Privacy Officer if I do not understand any information contained in the Notice of Privacy Practices.

AUTHORIZATION FOR EXAMINATION, TREATMENT & CLAIMS PROCESSING

I hereby authorize and consent to all examination and treatment necessary for the care of the patient named on this form. I consent to all procedures incident to such treatment that are deemed necessary by the provider. I authorize the release of medical information needed to process my claims, and I authorize Wellington Orthopedic Institute, LLC to receive insurance payment directly for services rendered.

AUTHORIZED PERSONS WHO MAY ACCESS MEDICAL INFORMATION

I hereby consent to the release of any and all information regarding my medical history, current medical condition, current medical treatment, and patient account information to the individual(s) listed below. If you do not want any information released, please leave this section blank.

Name	Relationship	Phone (optional)
Name	Relationship	Phone (optional)
Name	Relationship	Phone (optional)

PATIENT PORTAL

We invite you to join our patient portal. The portal allows you to communicate with your provider, view upcoming appointments, and review your health information, including but not limited to lab results.

Email Address for Patient Portal Registration

_____

Note: this packet is designed to be printed and signed by hand. If the practice later offers an electronic-signature option, a signature captured through that approved process has the same effect as a handwritten signature on this form. Do not send completed forms containing medical information by regular email; bring them to the office or use a secure channel provided by our staff. Do not include your full Social Security number in any email or online message.

Signature of Patient and/or Guardian	Relationship to Patient	Date

Witness (Staff)	Date