ANDREWS INSTITUTE
ORTHOPAEDICS & SPORTS MEDICINE
An Affiliate of Baptist Health Care

Dear New Patient,

Welcome! Thank you for the opportunity to assist you with your orthopaedic problem. The following information will help you prepare for your visit with Dr. Jordan. We look forward to seeing you.

Please bring all past medical records and any study results related to your current problem to your first visit. If you have had X-rays, MRI, CT scan, or other imaging, we need both a report and a disc with the images. You can obtain these from the facility where you had them done, or have them forwarded to our office prior to your appointment.

If you cannot make your appointment, please notify our office.

If you need language translation or interpreter assistance, please notify us in advance so we can make arrangements.

Please complete the enclosed new patient paperwork prior to your first appointment. You may return it via email or fax (850) 916-8764, or present it at check in. Please bring your current insurance card and driver's license to your first appointment.

We appreciate the opportunity to provide you with orthopedic care as well as your cooperation in following the above guidelines. Should you have any questions, please do not hesitate to call our office at (850) 916-8760.

Sincerely,
Kristina C. Beardsley, MSAT, ATC
Practice/Surgery Coordinator

1040 Gulf Breeze Parkway Suite 203 Gulf Breeze, Florida 32561
Tel: 850.916.8760 Fax: 850.916.8764
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Patient Name: _____
First MI Last Preferred Name Today's Date

_____ Sex: Male Female
Social Security Number Date of Birth Email Address

_____
Street Address City State Zip

Home #: _____ Cell #: _____ Work#:_____

Marital Status: Married Single Divorced Widowed

Race: African American American-Indian Asian Caucasian Hispanic Other

Injured/Painful Body Part: _____ Affected Side: RIGHT LEFT

Date Problem Began or Injury Occurred: _____

Description of injury:_____

_____

_____

Occupation _____ Hobbies_____

Athletes: Please complete all that apply:

Sport: _____ Position: _____ Level :_____

Team: _____ Coach's Name: _____ Athletic Trainer's Name: _____

Student / School_____ Yr/Grade: _____

Guardian Information: (If Patient is a Minor):

_____
First MI Last Relationship to Patient Social Security Number

_____ Sex: Male Female
Date of Birth Contact Phone Number

ONLY FILL OUT THIS SECTION IF YOU WERE IN JURED IN AN AUTO ACCIDENT:

Did this injury occur as a result of a motor vehicle accident? Y N
Have you had emergency treatment for this injury? Y N Do you have a lawyer? Y N

ONLY FILL OUT THIS SECTION IF THIS INJURY IS RELATED TO AN ON THE JOB ACCIDENT:

(Professional athletes may skip this section)
Did this injury occur while you were working? Y N
Name of Employer: _____ Date Reported: _____
Your Position _____ Are you working? Y N Light Duty

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Medical History: Check if you have had any of these **medical problems** in the **PAST**:

MAJOR ILLNESS	YES	NO	**MAJOR ILLNESS**	YES	NO
Anemia			Diabetes: Type_____		
Bleeding Disorder: Type_____			Gall Bladder Disease		
Blood Clots			Gastric Ulcers		
Stroke			GI Disorder		
Rheumatoid Arthritis			Cancer: Type _____		
HIV/AIDS			Kidney Disease		
Hepatitis: Type_____			Urinary Tract Infections		
Liver Disease			Neuropathy		
Asthma			Numbness/Tingling		
Lung Disorder			Eye Disorder: Type_____		
Chest pain/Angina			Psychiatric Illness		
Heart Problems			Wound Healing Problems		
High Blood Pressure			History of MRSA		
Thyroid Disease			OTHER:		

Please list any **operations/surgeries** you have had:

SURGERY	YEAR	**SURGERY**	YEAR
1)		4)	
2)		5)	
3)		6)	

Family Medical History: Please list **Major** illnesses that affect your family:

MEDICAL ILLNESS	RELATION	**MEDICAL ILLNESS**	RELATION
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Do you have any **drug allergies**? Yes No **LATEX** Allergy? Yes No

Please List:

_____

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Please list any **Medications** that you are currently taking: (Please continue on back if needed)

MEDICATION	DOSE	DATE AND TIME OF LAST DOSE
1)		
2)		
3)		
4)		
5)		
6)		

Preferred Pharmacy:_____ **City, State:**_____ **Phone:**_____

Social History:

Alcohol use:	Current	Past	Never
Illicit Drug use:	Current	Past	Never
Cigarette use:	Current	Past	Never

Review of Symptoms: Please mark any of the symptoms that you are **currently experiencing today**:

SYMPTOM	YES	NO	**SYMPTOM**	YES	NO
Chills			Painful Urination		
Fever			Frequent Urination		
Unexplained Weight Loss			Blood in Urine		
Vision Changes			Unexplained Skin Lesions		
Cough			Rash		
Shortness of Breath			Easy Bleeding		
Chest Pain			Easy Bruising		
Rapid Heartbeat			Anxiety		
Irregular Heartbeat			Depression		
Abdominal Pain			Dizziness		
Nausea			Tremors		
Vomiting			OTHER:		

Are these symptoms (unrelated to your orthopaedic condition) being treated by another Physician?

Yes **No**

Which Physician? _____

Height:_____ **Weight:**_____

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Payment Information:

Form of Payment: (circle) Health Insurance Auto Insurance Worker's Compensation Self Pay

Primary Insurance
Primary Insurance Company: _____ Insured's Name _____
Policy #: _____ Group #: _____ Insured's Date of Birth: _____

Secondary Insurance
Secondary Insurance Company: _____ Insured's Name _____
Policy #: _____ Group #: _____ Insured's Date of Birth: _____

Agreement of Accuracy: The information provided in this history form is true and complete to the best of my knowledge.

Notice of Privacy Practices: I am aware that Andrews Orthopaedic and Sports Medicine Center has a "Notice of Privacy Practices" in accordance with Baptist Health Care's privacy policies. I understand that a copy is available to me and I agree with these privacy policies.

Release of Information: I authorize Andrews Orthopaedic and Sports Medicine Center to release medical information requested by my health insurance, Medicare, or third-party payers in order to assist in the payment of claims.

Self Pay Agreement: I agree to pay for medical services rendered at Andrews Orthopaedic and Sports Medicine Center. Should my insurance deny payment, I am responsible for the entirety of my bill. I understand that there are payment plans available at my request.

I authorize Baptist Physicians Group to disclose my health care information and to discuss my health care needs with those that I designate. I further authorize the release of my billing information to the following individuals and give them the ability to pick up prescriptions and/or forms. etc, on my behalf. A photo ID is required for any pick up. These individuals will be considered my emergency contacts. Without authorization, no information may be shared.

Important Note: If you may want or need any healthcare information or scheduling information released to any individuals they need to be specifically listed below. This includes individuals such as: a parent or child of a patient over 18 years of age, your primary care physician, your insurance policy holder, and/or sport coaches etc.

I authorize Baptist Physicians Group and their staff to disclose my personal health information to the following people:

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

I acknowledge that I have reviewed the above information.

_____ _____
Patient Signature **Date**

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