

200 Doctors Drive  
Panama City, FL 32405  
Phone: 850-784-7724  
Fax: 850-784-4711



710 Hospital Drive  
Crestview, FL 32539  
Phone:850-398-8480  
Fax:850-398-8482

**PATIENT INFORMATION RECORD**

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Address: \_\_\_\_\_  
\_\_\_\_\_  
(City) (State) (Zip)

Phone: \_\_\_\_\_  
(Home) (Work) (Other)

Sex: M or F Marital Status: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Pharmacy Preference (include location): \_\_\_\_\_

Is this problem the result of an Injury: \_\_\_\_ Yes \_\_\_\_ No

Type of Injury: \_\_\_\_ Auto \_\_\_\_ Work \_\_\_\_ Sport \_\_\_\_ Other (Please fill out accident info sheet)

Have you been treated by another physician for this problem: \_\_\_\_ Yes \_\_\_\_ No

If yes, when and where:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

200 Doctors Drive  
Panama City, FL 32405  
Phone: 850-784-7724  
Fax: 850-784-4711



710 Hospital Drive  
Crestview, FL 32539  
Phone:850-398-8480  
Fax:850-398-8482

## PANHANDLE ORTHOPAEDICS PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form.

**Are you taking any medications now?** (This includes prescription, over-the-counter or herbal medications.)

No  Yes **If yes, please list below.**

Medication Name

**ARE YOU ALLERGIC TO ANY MEDICATIONS?**  No  Yes **If yes, please list below.**

Medication Name

**Are you allergic to contrast dye?**  No  Yes

**If yes, what reaction do you have?** \_\_\_\_\_

**Are you allergic to any non-medical things such as latex, tape, metal, iodine?**  No

latex  tape  metal  iodine

**Are you pregnant?**  No  Yes

\_\_\_\_\_  
Patient/Guardian (sign)

\_\_\_\_\_  
Patient/Guardian (Print)

**Patient Name** (Print): \_\_\_\_\_

**Patient DOB:** \_\_\_\_\_

**Date:** \_\_\_\_\_

200 Doctors Drive  
Panama City, FL 32405  
Phone: 850-784-7724  
Fax: 850-784-4711



710 Hospital Drive  
Crestview, FL 32539  
Phone:850-398-8480  
Fax:850-398-8482

**Have you ever been *DIAGNOSED* with any of the following problems?**

**Cancer:**  No  Yes  
 bone  breast  lung  thyroid  
 prostate  kidney

**Currently undergoing:**  
Chemotherapy  No  Yes  
Radiation  No  Yes

**Heart:**  
High blood pressure  No  Yes  
Heart failure  No  Yes  
Heart disease  No  Yes  
PVD  No  Yes

**Lungs and Respiratory:**  
Tuberculosis  No  Yes  
Asthma  No  Yes  
COPD  No  Yes

**Stomach:**  
Stomach ulcer  No  Yes

**Neurological:**  
Stroke  No  Yes

**Kidney:**  
Renal failure  No  Yes

**Glands, Hormones, & Sugar Control:**  
Diabetes  No  Yes  Type 1  Type 2  
Hyperthyroid(high function)  No  Yes  
Hypothyroid(low function)  No  Yes  
Osteoporosis  No  Yes

**Blood & Lymph Node:**  
Anemia  No  Yes  
Thalassemia  No  Yes  
Blood clots  No  Yes  
Clotting abnormalities  No  Yes

**Allergies, Immune & Infectious Problems:**  
HIV  No  Yes Hepatitis  No  Yes

**SURGERIES AND HOSPITALIZATIONS:**

Please list only *BONE* and *JOINT* surgeries or those relevant to today's visit:

Surgery	Date

**Have you had problems with anesthesia (being numbed or put to sleep)?**  No  Yes  
 high fever  trouble with intubation (placement of breathing tube.)

**FAMILY HISTORY:**

**Stroke**  
 Mother  Father  Brother  Sister

**Bleeding/clotting problems**  
 Mother  Father  Brother  Sister

\_\_\_\_\_  
Patient/Guardian (sign)

\_\_\_\_\_  
Patient/Guardian (Print)

**Patient Name** (Print): \_\_\_\_\_

**Patient DOB:** \_\_\_\_\_

**Date:** \_\_\_\_\_

200 Doctors Drive  
Panama City, FL 32405  
Phone: 850-784-7724  
Fax: 850-784-4711



710 Hospital Drive  
Crestview, FL 32539  
Phone: 850-398-8480  
Fax: 850-398-8482

**SOCIAL HISTORY:** What is/was your occupation? \_\_\_\_\_ Retired?  No  Yes

Do you currently use tobacco in any form?  No  Yes

Are you dependent on alcohol?  No  Yes

Are you or have you been dependent or addicted to any drug?  No  Yes

Marijuana  Cocaine  Morphine  Heroin  Diazepam (Valium)  Soma

Dominant hand:  Left  Right

Do you exercise on a regular basis?  No  Yes How often? \_\_\_\_\_

Living setting:  Alone  Spouse  Children  Mother  
 Father  Nursing Home  Assisted living  other \_\_\_\_\_

Do you have a history of long term steroid use?  No  Yes

**REVIEW OF SYSTEMS:** Mark yes or no and CHECK any of the following you have recently had:

**General health problems:**  No  Yes

- dizziness
- fever
- unintentional weight loss

**Mouth & throat problems:**  No  Yes

- ulcers
- neck masses or lumps
- swollen glands

**Heart or circulation problems:**  No  Yes

- blacking out or fainting
- bluish discoloration of lips or fingernails
- irregular heartbeat
- leg cramps
- swelling of ankles
- chest pain

**Lung or respiratory problems:**  No  Yes

- frequent productive cough
- shortness of breath

**Stomach problems:**  No  Yes

- abdominal pain
- heartburn

**Bones, Joints and Muscles:**  No  Yes

- painful joints
- swelling of joints
- pain in back
- stiffness
- neck pain

**Brain or Nervous system problems:**  No  Yes

- loss of bladder control
- bowel problems
- seizures
- weakness
- loss of consciousness
- numbness

**Problems with Glands, Hormones:**  No  Yes

- feel cold all the time
- feel hot when others do not

**Problems with Blood or Lymph nodes:**  No  Yes

- bleeds excessively after injury
- bruises easily

**Problems with Allergies:**  No  Yes

- hives

\_\_\_\_\_  
Patient/Guardian (Sign)

\_\_\_\_\_  
Patient/Guardian (Print)

**Patient Name** (Print): \_\_\_\_\_

**Patient DOB:** \_\_\_\_\_

**Date:** \_\_\_\_\_

200 Doctors Drive  
Panama City, FL 32405  
Phone: 850-784-7724  
Fax: 850-784-4711



710 Hospital Drive  
Crestview, FL 32539  
Phone:850-398-8480  
Fax:850-398-8482

**ACCIDENT INFORMATION SHEET**

In Order to expedite the payment of your claim, we are requesting you complete the following information which will be sent to your insurance company

**Name of injured party:** \_\_\_\_\_

**Date of Injury:** \_\_\_\_\_

**Please provide a detailed description of when, where, how the injury occurred:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The above information is true and correct to the best of my knowledge:**

\_\_\_\_\_  
Patient/Guardian (sign)

\_\_\_\_\_  
Patient/Guardian (Print)

**Patient Name (Print):** \_\_\_\_\_

**Patient DOB:** \_\_\_\_\_

**Date:** \_\_\_\_\_

200 Doctors Drive  
Panama City, FL 32405  
Phone: 850-784-7724  
Fax: 850-784-4711



710 Hospital Drive  
Crestview, FL 32539  
Phone: 850-398-8480  
Fax: 850-398-8482

## PROTECTED HEALTH INFORMATION RELEASE AUTHORIZATION

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

SSN: \_\_\_\_\_

Treating Physician: \_\_\_\_\_

I, \_\_\_\_\_ request and authorize the above listed doctor and/or practice to release health care information of the above named patient to: Michael Gilmore M.D.

200 Doctors Drive  
Panama City, FL 32405  
Phone: 850-784-7724  
Fax: 850-784-4711

710 Hospital Drive  
Crestview, FL 32539

This request and authorization applies to health care information relating to any treatment or care I received, including, but not limited to, AIDS/HIV, drug and/or alcohol abuse, Psychiatric, etc.

I may cancel my authorization to the extent allowed by law. If I do, I understand that the doctor and/or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor and/or practice in reliance on my original authorization.

There are two (2) ways to cancel this agreement. I can:

- Sign and date a form available from the doctor or practice call "Revocation of Authorization for Use and Disclosure of Health Care Information" or,
- Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the persons(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter

Once my doctor gives out the information that I want to release, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information may re-disclose it. Federal or State privacy laws may no longer protect the information.

\_\_\_\_\_  
Patient/Guardian (sign)

\_\_\_\_\_  
Patient/Guardian (Print)

Patient Name (Print): \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Date: \_\_\_\_\_

EXPIRATION DATE: This authorization will expire one year from date signed.

200 Doctors Drive  
Panama City, FL 32405  
Phone: 850-784-7724  
Fax: 850-784-4711



710 Hospital Drive  
Crestview, FL 32539  
Phone:850-398-8480  
Fax:850-398-8482

**CANCELLATION NOTICE**

We ask you to show consideration by calling well in advance if you are unable to keep an appointment. We would like to have the option to offer that appointment to another patient who needs to see the doctor.

Please let this notice serve to notify you that if you fail to give us a 24 hour notice of cancellation, there will be a \$25.00 cancellation fee billed to your account that cannot be filed to your insurance. If you repeatedly miss appointments we may be forced to dismiss you from our practice.

We are concerned that you may not be receiving proper medical care because of missed appointments. Please call if you are experiencing any problems.

We value you as a patient.

\_\_\_\_\_  
Patient/Guardian (sign)

\_\_\_\_\_  
Patient/Guardian (Print)

Patient Name (Print): \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

200 Doctors Drive  
Panama City, FL 32405  
Phone: 850-784-7724  
Fax: 850-784-4711



710 Hospital Drive  
Crestview, FL 32539  
Phone:850-398-8480  
Fax:850-398-8482

**AUTHORIZATION FOR TREATMENT**

I hereby authorize Michael Gilmore, M.D., or whomever he may designate as assistant to render medical care to me. I consent to care and treatment that may encompass diagnostic, laboratory or any medical treatment deemed by Michael Gilmore M.D. or his assistant in exercise of professional judgment to be of appropriate kind and method on me/my dependent.

\_\_\_\_\_  
Patient/Guardian (sign)

\_\_\_\_\_  
Patient/Guardian (Print)

Patient Name (Print): \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Date: \_\_\_\_\_



200 Doctors Drive  
Panama City, FL 32405  
Phone: 850-784-7724  
Fax: 850-784-4711



710 Hospital Drive  
Crestview, FL 32539  
Phone:850-398-8480  
Fax:850-398-8482

## INSURANCE AND PAYMENT INFORMATION

### Primary Insurance Plan:

Insurance Company: \_\_\_\_\_  
\_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

### **If policyholder other than patient:**

Policy Holder's SSN: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

Birth date: \_\_\_\_\_

### Secondary Insurance Plan:

Insurance Company: \_\_\_\_\_  
\_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

### **If policyholder other than patient:**

Policy Holder's SSN: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

Birth date: \_\_\_\_\_

All co-payments, deductibles and co-insurance are due at time of service. For your convenience we accept checks, cash and credit cards. We also provide "Care Credit", please ask the receptionist for more details about this service.

After 90 days if your bill has not been paid and you have not made prior arrangements with our billing department your outstanding account will automatically be sent to collections. We will be happy to answer any questions you may have about your bill.

I hereby assign to and authorize payment to Panhandle Orthopaedics, P.A. of all benefits under the terms of my insurance policy listed above. I agree to pay my percentage of the claim or the entire bill, if necessary. Should insurance deny my claim for any reason, I understand and agree that I am fully responsible for the entire bill or any portions not covered by insurance. I further understand my insurance company may deem procedures my physician feels necessary to be unnecessary and therefore not payable. I understand that because my insurance may not pay for a particular item or service does not mean that I or my dependent should not receive it. If my insurance denies payment, I agree to be personally and fully responsible for payment to Michael Gilmore, M.D. / Panhandle Orthopaedics, P.A.

\_\_\_\_\_  
Patient/Guardian (sign)

\_\_\_\_\_  
Patient/Guardian (Print)

Patient Name (Print): \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Date: \_\_\_\_\_

200 Doctors Drive  
Panama City, FL 32405  
Phone: 850-784-7724  
Fax: 850-784-4711



710 Hospital Drive  
Crestview, FL 32539  
Phone:850-398-8480  
Fax:850-398-8482

## How did you hear about us?

Please take this time to let us know how you found out about us.

Internet, our website

Internet, another website

Friend

Phonebook

Newspaper

Attorney

Another doctor

Magazine

Other

---

If other, please provide us with some detail:

---

---

---

Patient Name (Print): \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE IS CURRENTLY IN EFFECT AND REMAINS IN EFFECT UNTIL WE REPLACE IT.

### 1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

### 2. OUR LEGAL DUTY

#### **Law Requires Us to:**

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

#### **We Have the Right to:**

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

#### **Notice of Change to Privacy Practices:**

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

### 3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

**FOR TREATMENT:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

**FOR PAYMENT:** We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

**FOR HEALTH CARE OPERATIONS:** We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

**ADDITIONAL USES AND DISCLOSURES:** In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

**Facility Directory:** Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us for information about you by name.

**Notification:** We may use and disclose medical information to notify or help notify: a family member, your personal representative, or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

**Disaster Relief:** We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

**Fundraising:** We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

**Research in Limited Circumstances:** We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

**Funeral Director, Coroner, and Medical Examiner:** To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

**Specialized Government Functions:** Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing health benefits.

**Court Orders and Judicial and Administrative Proceedings:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

**Public Health Activities:** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

**Victims of Abuse, Neglect, or Domestic Violence:** We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health and safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

**Workers Compensation:** We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

**Health Oversight Activities:** We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure, or disciplinary actions, or other authorized activities.

**Law Enforcement:** Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

**Appointment reminders:** We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

**Alternative and Additional Medical Services:** We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

### 4. YOUR INDIVIDUAL RIGHTS

#### **You Have a Right to:**

1. Look at or get legal copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you one dollar a page for the first twenty-five pages with each sheet to follow costing twenty-five cents in addition to postage if you request these copies by mail. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changes or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including the people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person at the end of this notice.