



**Panama City**  
 200 Doctors Drive  
 Panama City, FL 32405  
 Ph: (850) 784-7724

**Crestview**  
 710 Hospital Drive  
 Crestview, FL 32539  
 Ph: (850) 398-8480

**Pensacola**  
 4724 North Davis Hwy.  
 Pensacola, FL 32503  
 Ph: (850) 398-8480

**PATIENT INFORMATION RECORD**

Name: \_\_\_\_\_  
 (last) (first) (middle initial)

Address: \_\_\_\_\_  
 (street)  
 \_\_\_\_\_  
 (city) (state) (zip)

Email: \_\_\_\_\_

Phone: \_\_\_\_\_  
 (home) (work) (other)

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

Sex: M F Race: Asian Black Native American Native Hawaiian White Other  
 Ethnicity: Hispanic Latino Not Hispanic nor Latino Language: English Spanish  
 Other \_\_\_\_\_

Marital Status: Married Single Divorced Widowed Legally Separated

Employer: \_\_\_\_\_ Employer Phone Number: \_\_\_\_\_

Reason for today's visit:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Is this problem the result of an injury: YES NO If yes, please complete the remaining questions.

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:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



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## 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.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

YES NO If yes, please list below.

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Are you allergic to any medications?

YES NO If yes, please list below.

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Are you allergic to contrast dye?

YES NO If yes, what reaction do you have?

Are you allergic to any non-medical things such as latex, tape, metal, iodine?

YES NO If yes, please check which ones.

latex      tape      metal      iodine      other

- |   |    |                            |
|---|----|----------------------------|
| Have you received the pneumococcal vaccination? | No | Yes                        |
| Have you had mammogram in the last 2 years      | No | Yes (month/year) ____/____ |
| Have you had the influenza immunization?        | No | Yes (month/year) ____/____ |

  X    
 \_\_\_\_\_  
 Patient/Guardian (signature)

\_\_\_\_\_  
 Patient/Guardian (print)

Patient Name (print): \_\_\_\_\_

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



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

<b>Cancer</b>	No	Yes		<b>Kidney</b>		
bone	breast	lung	thyroid	Renal failure	No	Yes
prostate	kidney	skin	other	<b>Bones, Joints, and Muscles</b>		
<b>Currently undergoing</b>				Osteoporosis	No	Yes
Chemotherapy		No	Yes	Arthritis	No	Yes
Radiation		No	Yes	<b>Neurological</b>		
<b>Heart</b>				Stroke	No	Yes
High blood pressure		No	Yes	<b>Glands, Hormones, &amp; Sugar Control</b>		
Heart attack		No	Yes	Diabetes	No	Yes
Heart disease		No	Yes		Type 1	Type 2
CHF		No	Yes	Hyperthyroid	No	Yes
<b>Lungs and Respiratory</b>				Hypothyroid	No	Yes
Tuberculosis		No	Yes	<b>Blood &amp; Lymph Node</b>		
Asthma		No	Yes	Anemia	No	Yes
COPD		No	Yes	Thalassemia	No	Yes
<b>Stomach</b>				Blood Clots	No	Yes
Stomach Ulcer		No	Yes	<b>Immune &amp; Infectious Problems</b>		
Hepatitis		No	Yes	HIV	No	Yes
Are you pregnant		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.) other \_\_\_\_\_

**Family History**

Stroke Bleeding/Clotting Problems  
 Mother Father Brother Sister Mother Father Brother Sister

  X    
 Patient/Guardian (signature)

\_\_\_\_\_  
 Patient/Guardian (print)

Patient Name (print): \_\_\_\_\_

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

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







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**AUTHORIZATION FOR ACQUISITION OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This is to authorize the disclosure of my protected health information to the following provider:

Michael D. Gilmore, M.D./Panhandle Orthopaedics P.A.

710 Hospital Drive  
Crestview, FL 32539

6706 N. 9th Avenue, Suite A4  
Pensacola, FL 32504

200 Doctors Drive  
Panama City, FL 32405

Dr. Gilmore has authorization to receive copies of all medical records/diagnostic testing for all dates of care.

X  
\_\_\_\_\_  
Patient/Guardian (signature)

\_\_\_\_\_  
Patient/Guardian (print)

Patient Name (print): \_\_\_\_\_

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



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### 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.

X \_\_\_\_\_  
Patient/Guardian (signature)

\_\_\_\_\_  
Patient/Guardian (print)

Patient Name (print): \_\_\_\_\_

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



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## 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.

X  
\_\_\_\_\_  
Patient/Guardian (signature)

\_\_\_\_\_  
Patient/Guardian (print)

Patient Name (print): \_\_\_\_\_

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

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



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Dear Patient:

Panhandle Orthopaedics, PA, in accordance with HIPAA and FDCPA, has instituted a policy that we will not discuss any medical and/or billing information to ANY member of your family without specific written consent, including spouses. Please notify your family members of our policy and understand we are simply complying with federal and state rules and regulations concerning privacy.

**AUTHORIZED PATIENT NOTIFICATION LIST**

I authorize Dr. Michael Gilmore and whomever he may designate as his professional representative to discuss any aspect of my orthopaedic care, to include: appointments, tests, test results, surgical procedures, prescriptions, billing/balance information and any other pertinent information pertaining to my care with the following designated\* individuals:

(Designated individuals to include: parents, children, spouse, coach, attorney, etc.)

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____

This document will be a part of your permanent record. In the event that any of the designated individuals change, it will be necessary to update our records with a written notification stating whom you would like to add to or delete from your list.

X  
 \_\_\_\_\_  
 Patient/Guardian (signature)

\_\_\_\_\_  
 Patient/Guardian (print)

Patient Name (print): \_\_\_\_\_

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

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



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## INSURANCE AND PAYMENT INFORMATION

### Primary Insurance Plan:

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

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

Policy Identification #: \_\_\_\_\_ Birth date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

### Secondary Insurance Plan:

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

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

Policy Identification #: \_\_\_\_\_ Birth date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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.

X

\_\_\_\_\_  
Patient/Guardian (signature)

\_\_\_\_\_  
Patient/Guardian (print)

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**How did you hear about us?**

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

Internet, our website

Insurance website

Friend

Phonebook

Billboard

Attorney

Another doctor

Magazine

Radio Health Tip

If other, please provide us with some detail:

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X  
\_\_\_\_\_  
Patient/Guardian (signature)

\_\_\_\_\_  
Patient/Guardian (print)

Patient Name (print): \_\_\_\_\_

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

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