PANHANDLE ORTHOPAEDICS

12909 Panama City Beach Pwy.
Panama City Beach, FL 32407
850-784-7724 - Fx: 850-784-4711

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

4624 N. Davis Highway
Pensacola, FL 32503
850-398-8480 - Fx: 850-398-8482

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 **If female are you pregnant:** ☐ Yes ☐ No

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:

Patient/Guardian (please sign) _____ **Social Security #:** _____

Patient DOB: _____ **Date:** _____

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PANHANDLE ORTHOPAEDICS PATIENT HEALTH HISTORY

IMPORTANT: Please fill out this form as completely as possible so we may obtain a complete medical history.

Please be advised that you have not established a physician-patient relationship with this practice until Dr. Gilmore reviews your health history, conducts an initial evaluation and determines whether it is in your best medical interest for you to become a patient of the practice.

Please fill out every item so that doctor and staff know that you have carefully reviewed every area of this form.

Height: _____ **Weight:** _____

Are you taking any medications now? ☐YES ☐NO If yes, please list below.

(This includes prescription, over-the-counter, or herbal medications.)

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?

Describe here:_____

Allergies to non-medical things such as latex, tape, metal, iodine? ☐YES ☐NO If yes, please check below.

☐latex ☐tape ☐metal ☐iodine ☐other

Patient/Guardian (please sign)_____

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

Cancer ☐ No ☐ Yes
☐ bone ☐ breast ☐ lung ☐ thyroid
☐ prostate ☐ kidney ☐ skin ☐ other

Currently undergoing
Chemotherapy ☐ No ☐ Yes
Radiation ☐ No ☐ Yes

Heart
High blood pressure ☐ No ☐ Yes
Heart attack ☐ No ☐ Yes
Heart disease ☐ No ☐ Yes
CHF ☐ No ☐ Yes

Lungs & Respiratory
Tuberculosis ☐ No ☐ Yes
Asthma ☐ No ☐ Yes
COPD ☐ No ☐ Yes

Stomach
Stomach Ulcer ☐ No ☐ Yes
Hepatitis ☐ No ☐ Yes
Are you pregnant ☐ No ☐ Yes

Kidney
Renal failure ☐ No ☐ Yes

Bones, Joints & Muscles
Osteoporosis ☐ No ☐ Yes
Arthritis ☐ No ☐ Yes

Neurological
Stroke ☐ No ☐ Yes
Seizures ☐ No ☐ Yes

Glands, Hormones & Sugar Control
Diabetes ☐ No ☐ Yes
TYPE 1 TYPE 2
Hyperthyroid ☐ No ☐ Yes
Hypothyroid ☐ No ☐ Yes

Blood & Lymph Nodes
Anemia ☐ No ☐ Yes
Thalassemia ☐ No ☐ Yes
Blood Clots ☐ No ☐ Yes

Immune & Infectious Problems
HIV ☐ No ☐ Yes
AIDS ☐ No ☐ Yes

Surgeries and Hospitalizations

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 ☐ Mother ☐ Father ☐ Brother ☐ Sister **Heart Attack** ☐ Mother ☐ Father ☐ Brother ☐ Sister

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

Patient/Guardian (please sign)_____

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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 ☐ 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 RECENT HEALTH SYSTEMS

Please mark "yes" or "no" and check any of the following you have had in the last month.

General Health Problems ☐ No ☐ Yes
- ☐ Dizziness
- ☐ Fever
- ☐ Unintentional weight loss

Mouth & Throat Problems ☐ No ☐ Yes
- ☐ Ulcers

Heart or Circulation Problems ☐ No ☐ Yes
- ☐ Blacking out or fainting
- ☐ Bluish discoloration of lips or fingernails
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Irregular heartbeat
- ☐ Leg cramps
- ☐ Swelling of ankles

Lung or Respiratory Problems ☐ No ☐ Yes
- ☐ Frequent productive cough
- ☐ Shortness of breath

Stomach Problems ☐ No ☐ Yes
- ☐ Abdominal pain
- ☐ Heartburn

Bones, Joints & Muscles ☐ No ☐ Yes
- ☐ Pain in back
- ☐ Pain in neck
- ☐ Painful joints
- ☐ Stiffness in joints
- ☐ Swelling in joints

Brain or Nervous System Problems ☐ No ☐ Yes
- ☐ Loss of bladder control
- ☐ Loss of bowel control
- ☐ Loss of consciousness
- ☐ Numbness
- ☐ Seizures
- ☐ Weakness

Problems with Glands, Hormones ☐ No ☐ Yes
- ☐ Feels hot when other do not
- ☐ Feels cold

Problems with Blood or Lymph Nodes ☐ No ☐ Yes
- ☐ Bleeds excessively after injury
- ☐ Bruises easily

Problems with Allergies ☐ No ☐ Yes
- ☐ Hives ☐ Other / Seasonal

Patient/Guardian (please sign)_____

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INSURANCE AND PAYMENT INFORMATION

Primary Insurance Plan:

Was this plan purchased through the Healthcare Exchange? ☐ NO ☐ YES

Insurance Company: _____ Policy Holder's Name: _____

If policyholder other than patient:

Policy Identification #: _____ Birth date: _____

Relationship to Patient: _____

Secondary Insurance Plan:

Was this plan purchased through the Healthcare Exchange? ☐ NO ☐ YES

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. You agree to apply for or assist in the application for any program that coordinates charity care, if necessary.

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, LLC, 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, LLC.

I agree that the facility, Panhandle Orthopaedics, LLC, or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using email at any email address I provide to the facility or is otherwise associated with my account.

Patient/Guardian (please sign)_____

Patient DOB: _____ **Date:** _____

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, LLC

Panama City - 850-784-7724
200 Doctors Dr., Florida 32405

Crestview - 850-398-8480
710 Hospital Dr., Florida 32539

Pensacola - 850-398-8480
4624 N. Davis Hwy., Florida 32503

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. I understand that such diagnostic and laboratory services may include initial and follow-up medication monitoring as deemed necessary and appropriate by Michael Gilmore M.D., and as provided for under Florida law.

I hereby agree that medical services that are recommended but not undertaken, against medical advice, for any reason to include but not be limited to any financial limitations are foregone with the express understanding and acceptance of any resultant adverse outcome, and I waive any claim that may result from acting against medical advice.

I hereby agree that any of my actions taken against medical advice are undertaken at my own risk and I accept any resultant adverse outcome.

Patient/Guardian (please sign)_____ **Social Security #:**_____

Patient DOB: _____ **Date:** _____

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Dear Patient:

Panhandle Orthopaedics, LLC, 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.

AUTHORIZATION FOR 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.

WAIVER OF LIABILITY FOR NON PATIENTS

I hereby agree that the duty to supervise, protect and care for family members or friends that accompany me at Panhandle Orthopaedics is mine, or that of my family or friends. Neither Panhandle Orthopaedics nor Dr. Michael Gilmore is responsible for the monitoring, safety or protection of non-patients that accompany me in or around the premises of Panhandle Orthopaedics, and I expressly waive any liability of Panhandle Orthopaedics or Dr. Michael Gilmore for any harm or injury to my family members or friends suffered in or around such premises.

Patient/Guardian (please sign)_____

Patient DOB: _____ **Date:** _____

ACCIDENT INFORMATION

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:

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 you will be responsible for on your next visit. 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 (please sign)_____

Patient DOB: _____ **Date:** _____

HOW DID YOU HEAR ABOUT US?

Please take a moment to let us know how you found out about us.

Thank you for your feedback.

TRADITIONAL REFERENCE

☐ Another Doctor_____ ☐ Workers' Compensation

☐ Attorney_____ ☐ Family/Friend

ADVERTISEMENT

☐ TV ☐ Phonebook ☐ Billboard ☐ Magazine/Journal ☐ Other_____

WEB/ONLINE

☐ Insurance Site ☐ Google/Bing Search ☐ Healthgrades ☐ Vitals ☐ Other_____

SOCIAL MEDIA

☐ Facebook ☐ Twitter ☐ Google+ ☐ LinkedIn ☐ Youtube

OTHER

Describe _____

Patient Name: _____ **Date:** _____