



Date _____ PHYSICIAN _____ Account Number _____

Patient's Name _____ M ___ F ___ Age _____
Last First Middle

Date of birth _____ Patient Social Security Number _____

Race: circle one Asian Native Hawaiian Other Pacific Islander Black/African American
American Indian/Alaska Native White More than 1 race Unreported/refuse to release

Ethnicity: Circle one Hispanic/Latino Not Hispanic/Latino Unreported/refuse to release

Language: Circle one English French Spanish Creole Other

Parent or guardian Name (if patient under 18) _____

Mailing address _____
Street city state zip code – plus 4

Actual Street address if mailing address is a P.O. Box _____

Home Phone _____ Work Phone _____ Cell number _____

In case of an Emergency contact (name) _____ phone _____

Patient's Employer _____ Occupation _____

Employer's address _____
Street city state zip code

INSURANCE INFORMATION:

Subscriber name _____

Social Security number _____ Date of birth _____

Subscriber Employer _____ Phone number _____

Address _____

If work related accident name of person to contact _____

Attention: Required for all patients over 18 years old: Give the names of people you authorize us to discuss your medical care and financial obligations:

About X-rays: All x-rays taken are the property of Brevard Orthopaedics. X-rays are a part of your medical file and must be maintained as part of your medical record. The cost of x-rays includes taking the x-ray film, supplies, processing and interpretation.

Financial Responsibility/ Medical Records

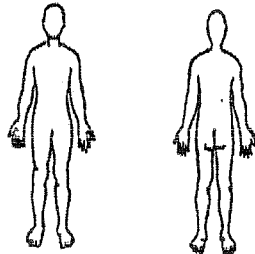
I have read and fully understand the financial policy and HIPPA policy established by Brevard Orthopaedics. I agree that insurance payments are to be paid to Brevard Orthopaedics on my behalf. I understand that I am financially responsible for all charges not paid by insurance. In the case of a minor, the child's guarantor is responsible for the account. Patient portion of charges and co-pays are due at the time services are rendered.

I have received a copy of Brevard Orthopaedics Notice of Privacy Practices and have the right to review the Notice prior signing this consent. Brevard Orthopaedics reserves the right to revise its Notice of Privacy Practices at anytime. The Notice of Privacy Practices is posted in our lobby.

Patient (Parent or Guardian if minor) signature _____
Relationship to patient _____ SS# _____ Printed name _____

TRANSYLVANIA

HEALTH SYSTEM

Date	Patient's Name	Date of Birth	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	Family Physician	Referring Physician (if different)		
Reason for today's visit & how long ago did this start and how did it happen? <input type="checkbox"/> work related <input type="checkbox"/> accident <input type="checkbox"/> no injury DATE OF INJURY _____				
List any previous treatment for this problem:				
Current Medications, Herbs & Supplements		Dosage	Current Medication (List additional on back.)	
1.			4.	
2.			5.	
3.			6.	
Drug Allergies or problems with medications (problem: nature of allergic reaction)				
All Previous Surgery (List additional on back)			Year of Surgery	Complications
1.				
2.				
3.				
Review of Organ Systems: In the past six months have you had?				Pain Scale Indicate level and location of pain. 10 High 9 8 7 6 5 4 3 2 1 Low 
<input type="checkbox"/> Repeated fevers <input type="checkbox"/> Irregular heartbeat/palpitations <input type="checkbox"/> Blackouts <input type="checkbox"/> Weight loss <input type="checkbox"/> Heartburn <input type="checkbox"/> Depression/anxiety <input type="checkbox"/> Vision problems <input type="checkbox"/> Diarrhea <input type="checkbox"/> Low energy level <input type="checkbox"/> Hearing difficulties <input type="checkbox"/> Painful or frequent urination <input type="checkbox"/> Sinus/allergy problems <input type="checkbox"/> Chest pain <input type="checkbox"/> Joint pain <input type="checkbox"/> Skin rash				
Family History: Have any of your blood relatives had?			Social History	
<input type="checkbox"/> Diabetes <input type="checkbox"/> Heart disease <input type="checkbox"/> Cancer _____ (type) <input type="checkbox"/> High blood pressure <input type="checkbox"/> Malignant hyperthermia <input type="checkbox"/> Neck/Back problems <input type="checkbox"/> Rheumatoid Arthritis			Marital status <input type="checkbox"/> married <input type="checkbox"/> single <input type="checkbox"/> divorced <input type="checkbox"/> widowed Do you have any children? <input type="checkbox"/> No <input type="checkbox"/> Yes How many? ____	
Medical History: At any time have you ever had?			Work Status <input type="checkbox"/> Employed <input type="checkbox"/> homemaker <input type="checkbox"/> retired <input type="checkbox"/> Unemployed <input type="checkbox"/> disabled <input type="checkbox"/> student Occupation _____ Hobbies/sports/interests _____	
<input type="checkbox"/> Diabetes <input type="checkbox"/> Treatment for drug or alcohol abuse <input type="checkbox"/> Stroke which side _____ <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Seizures <input type="checkbox"/> Thyroid trouble <input type="checkbox"/> Blood clots <input type="checkbox"/> Asthma <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Emphysema <input type="checkbox"/> HIV/AIDS/Venereal Disease <input type="checkbox"/> Skin disease _____ (type) <input type="checkbox"/> Stomach ulcers <input type="checkbox"/> Heart attack/ failure/Afib <input type="checkbox"/> Glaucoma <input type="checkbox"/> Anemia <input type="checkbox"/> Gallstones <input type="checkbox"/> Liver disease/hepatitis <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Cancer _____ (type) <input type="checkbox"/> Bowel/intestinal problems <input type="checkbox"/> Mental Health Disorder Type _____ <input type="checkbox"/> Depression / Bipolar <input type="checkbox"/> Prostate disease (males) <input type="checkbox"/> Kidney disease/stones Type _____ <input type="checkbox"/> High blood pressure <input type="checkbox"/> Gynecological disease (females) <input type="checkbox"/> Bleeding disorder / blood clot Type _____ Last tetanus shot _____ Other _____			Have you had a recent infection STD no yes High Cholesterol no yes Arthritis/ Gout no yes Current Smoker no yes ____ packs/day for ____ years Former Smoker no yes Year Stopped _____ Alcohol use once a day week month year rarely/never	

*Explanation for surgery problems or other medical problems if not marked above:



TRANSYLVANIA
HEALTH SYSTEM
Brevard Orthopaedics

Compound Authorization for Release of Information

Name of Patient _____

Date of Birth _____

Transylvania Physician Services, Inc. is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Check each person/entity that you approve to receive information and select what information can be released.

1	Voice Mail/Ans. Mach. Phone # _____	Fax # _____	E-mail _____
	<input type="checkbox"/> Results of lab tests/x-rays	<input type="checkbox"/> Appointment Information	
2	<input type="checkbox"/> Give information to employer	<input type="checkbox"/> Appointment Information	
3	<input type="checkbox"/> Give information to school	<input type="checkbox"/> Appointment Information	
Spouse _____			
	Name	Phone #	
4	<input type="checkbox"/> Results of lab tests/x-rays	<input type="checkbox"/> Appointment information	<input type="checkbox"/> Family billing information <input type="checkbox"/> Financial
Legal Guardian _____			
	Name	Phone #	
5	<input type="checkbox"/> Results of lab tests/x-rays	<input type="checkbox"/> Appointment information	<input type="checkbox"/> Family billing information <input type="checkbox"/> Financial
Other _____			
	Name	Phone #	
6	<input type="checkbox"/> Results of lab tests/x-rays	<input type="checkbox"/> Appointment information	<input type="checkbox"/> Family billing information <input type="checkbox"/> Financial
Please list any other information you would like released: _____			

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to the **Transylvania Physician Services, Inc** Privacy Officer. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority (attach necessary documentation)