Pediatric New Patient Medical History

Name: ____ Age: ______ MR#_____________ Today: ___/___/____

Chief Complaint: ____ Date of Injury: ___/___/_____

____________________________________ W: ____ lbs H: ___'___" DOB: ___/___/_____

Pediatrician: ____________________________________ Referring Physician: _______________________________

Are your injuries related to:

☐ Auto accident ☐ Work accident ☐ School Athletic accident ☐ Other accident ☐ None

Attorney: ☐ No ☐ Yes (name, phone, address): ____

____

Check off any diseases with which you were previously diagnosed

☐ AIDS/HIV
☐ Alcoholism
☐ Alzheimer's
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Blood Clots
☐ Cancer
☐ COPD
☐ Depression
☐ Diabetes
☐ Drug Abuse
☐ Eye Disease
☐ Fibromyalgia
☐ GI Reflux
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Hypercholesterolemia
☐ Hypertension
☐ Kidney Disease
☐ Osteoarthritis
☐ Osteoporosis
☐ Pacemaker
☐ Seizures
☐ Sleep Apnea
☐ Strokes
☐ Thyroid Disease
☐ Ulcers

☐ Right Handed ☐ Left Handed

Current Medications, Vitamins & Supplements

☐ **No Medications**

____ ____
____ ____
____ ____
____ ____
____

Pharmacy | Location: ________________________

Allergies (please list other drug allergies)

☐ None Known ☐ Codeine ☐ Iodine ☐ Sulfa ☐ Aspirin ☐ Penicillin ☐ Demerol ☐ Adhesive/Tape

Other: ____

Orthopedic Surgeries (please include side and year)

☐ **Arthroscopy**:
Side: ☐ R ☐ L Body Part: __________________

☐ **Spine**: ______________________

☐ **Replacement**:
Side: ☐ R ☐ L Body Part: __________________

☐ **Other**: _____________________

Other Surgeries

____ ____
____ ____

Fractures

____ ____

Last Updated: 9/25/2009

Pediatric New Patient Medical History

Name: ____ Age: _______ MR#_____________ Today: ___/___/____

What is the nature of the Patient's primary problem?

☐ Trauma ☐ Infectious ☐ Developmental ☐ Cerebral Palsy
☐ Tumor ☐ Spina Bifida ☐ Muscular Dystrophy ☐ Neuromuscular
☐ Other: ____

What part of the patient's body is involved? ____
Please describe what happened: ____

____

Have you had a problem before? If so, when? ____
Has anyone related to you had this problem before? If so, who? ____

What is your primary concern?

☐ Pain ☐ Deformity ☐ Appearance ☐ Future Problem ☐ Other: _________________________

Are you a CMS (Children's Medical Service) patient?

☐ No
☐ Yes: ☐ West Palm Beach ☐ Ft. Pierce

Previous diagnostic studies done for the problem?

☐ X-Rays Date: _____/_____/_____ Where: ____
☐ Cat Scan Date: _____/_____/_____ Where: ____
☐ MRI Date: _____/_____/_____ Where: ____
☐ Ultrasound Date: _____/_____/_____ Where: ____
☐ Bone Scan Date: _____/_____/_____ Where: ____
☐ EMG/NCS Date: _____/_____/_____ Where: ____

____

Please provide past medical history:

Medical Problems: ____

____

Problems related to birth: ____

____

Physician's Notes

Signature: ____

Last Updated: 9/25/2009

PALM BEACH ORTHOPAEDIC INSTITUTE, P.A.

3401 PGA Blvd., Ste 500, Palm Beach Gardens, FL 33410
1411 N Flagler Dr, Ste 9800, West Palm Beach, FL 33401
2055 Military Trail, Ste 200, Jupiter, FL 33458

FINANCIAL RESPONSIBILITY FORM

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need you assistance, and your understanding of our payment policy.

Payment for services is due upon check-in for your scheduled appointment. Payment is accepted in the form of cash, checks, MasterCard, Visa, American Express and Discover. Any exceptions to this or special arrangements must be made in advance with a financial counselor. We will be happy to provide you with a copy of your bill to file for reimbursement to you insurance carrier.

Patients with managed care plans with which we participate are responsible for appropriate co-pays, co-insurance, deductibles, and other services deemed not covered by the insurance plan. We do participate with many insurance plans and networks, however, these change frequently. We suggest you check your plan's Provider Directory and consult directly with your carrier before scheduling an appointment.

We will gladly discuss your proposed treatment and answer questions relating to your insurance. Please be aware, however, that your insurance is a contract between you, your employer, and the insurance company. Not all services are a covered benefit in all contracts. It is your responsibility to be familiar with the benefits and restrictions provided by your plan.

In certain situations, such as a scheduled surgery, you may be asked to pay a deposit based upon the procedure to be performed and the benefits verified by your insurance plan. This payment will also be expected in advance.

Please be advised that returned checks are subject to an additional charge of $25.00. The original amount and the additional charge must be paid in cash, credit card or cashier's check. Failure to do so may result in your account being referred to our collection agency.

Unpaid balances older than 90 days may be turned over to our collection agency. If this happens, you will be responsible for all legal fees and court cost incurred as a result.

You may not receive a bill from us while your insurance is processing your claims, however, all charges are your responsibility from the date the services rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

AUTOMOBILE ACCIDENT

I, the undersigned patient, hereby direct my Personal Injury Protection and/or Medical Payments Insurance Benefits Carrier to make payments for medical supplies and/or services rendered to me by Palm Beach Orthopaedic Institute as a result of the motor vehicle accident that occurred on _______________.

I authorize and direct my PIP and/or M/P insurance carrier to make any and all check or drafts payable solely to Palm Beach Orthopaedic Institute and forward same to the Palm Beach Orthopaedic Institute, at 3401 PGA Blvd, Suite 500, Palm Beach Gardens, FL 33410.

My signature below is an indication that the medical services being billed were, in fact, actually rendered, to the best of my knowledge and belief. Further, by the medical provider attests that such medical supplies and/or services were medically necessary and that the bill submitted for same is the reasonable and customary charge for said medical supplies and/or services.

I, ___________________________hereby authorize ___________________________to make medical benefits payments otherwise payable to me
(Name of Insured/Patients) (Name of Insurance Carrier)

for services rendered by Palm Beach Orthopaedic Institute, but not to exceed the charges of those services, payable to and mailed directly to:

Palm Beach Orthopaedic Institute
3401 PGA Blvd., Suite 500
Palm Beach Gardens, FL 33410

Furthermore, I hereby IRREVOCABLY ASSIGN to Palm Beach Orthopaedic Institute the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charges provided by Palm Beach Orthopaedic Institute.

Further, a photocopy of this executed document shall be sufficient in law as any original.

X-RAY POLICY

X-rays and MRI's obtained in this office are part of your **permanent record** and for legal purposes must remain in our office. Copies can be made at a charge of $10.00 for each x-ray film or per MRI disk.

DISPENSING OF DURABLE MEDICAL EQUIPMENT

I authorize the release of any medical information necessary to process the health insurance claim. I also request direct payment for durable medical equipment to American Medical, Inc. I hereby acknowledge and accept final responsibility for payment of charge for medical services rendered.

FINANCIAL AGREEMENT AND AUTHORIZATION

I authorize the patient's insurance company, attorney or Medicare to pay direct to Palm Beach Orthopaedic Institute any medical and/or surgical expenses payable under the terms of the contract. I also agree that any balance not covered will be paid by me and that photocopies of this form will be valid. I agree that should this account be referred to an agency or attorney for collection, that I will be responsible for all collection costs, attorney's fees and court costs.

I agree to the office policy of **Palm Beach Orthopaedic Institute** and wish to be seen. IN WITNESS WHEREOF the undersigned have hereunto set their hands:

Name of Patient (Please Print):____MR#:____________________DOB:__________________________

Signature:____Date Signed:____