Eaton Orthopaedics LLC
900 Carillon Parkway, Suite #311 • St. Petersburg, FL 33716
Phone: (727) 573-KOCO (5626) • Fax: (727) 573-5627
www.EatonOrtho.com

Dear Patient, All of this material is private and fully protected. - Eaton Orthopaedics

Patient Information

Today's Date:_____

Patient Name:_____ Birth Date:_____ Age:_____

Birth Place:_____ Best Phone Number:_____ ☐ Home ☐ Work ☐ Cell

Email Address:_____ Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ DP

Primary Care Physician:_____ PCP Phone Number:_____

Who referred you to our practice?:_____Referring Physician Phone Number_____

Background

Employed: ☐ Yes ☐ No Retired: ☐ Yes ☐ No Disabled: ☐ Yes ☐ No Employer:_____

Current or last occupation:_____ My job is/was: ☐ Sitting/Desk ☐ Light Physical ☐ Medium ☐ Hard

My hobbies are: ☐ None ☐ Physical Exercise/Work ☐ Walking/Staying Active ☐ Sedentary/Reading

Height:_____ ft. _____ in. Weight:_____ Hand Dominance: ☐ Right ☐ Left ☐ Both Recent or Frequent Falls ☐ Yes ☐ No

Current Problem

Orthopedic problems that you would like to discuss today:_____

My problem started:(____) years,(____) months,(____) weeks,(____) days ago. Is it the result of an injury: ☐ Yes ☐ No

Date of injury:_____ Injury details:_____

Did it happen at work: ☐ Yes ☐ No Result of auto accident: ☐ Yes ☐ No Is Litigation pending: ☐ Yes ☐ No

Check any/explain: ☐ Sharp pain ☐ Dull/aching ☐ Numbness ☐ Tingling ☐ Gradual onset ☐ Night Pain ☐ Swelling ☐ Clicking ☐ Locking

☐ Shooting Pain ☐ Other_____

Pain level 0-10 scale (0=no pain, 10 worst pain imaginable): Now _____ Daily average _____ At its worst_____ At its best_____

The following makes my pain worse: ☐ Hand Activity ☐ Overhead use ☐ Sleeping ☐ Exercise ☐ Work ☐ Stress ☐ Other_____

The following makes my pain better: ☐ Rest ☐ Ice ☐ Heat ☐ Exercise ☐ Splint ☐ Medication ☐ Therapy ☐ Other_____

Testing and Treatment

Prior to this visit, I have had the following tests for this problem:

☐ X-Ray ☐ MRI ☐ CT Scan ☐ Nerve Conduction Test ☐ Blood Test

Prior to this visit, I have had the following treatments for this problem:

☐ Rest ☐ Splinting ☐ Therapy ☐ Injection ☐ Surgery _____

Past Medical History

Please check or list all problems that you currently have or have had in the past ☐ None

☐ HIV+/AIDS	☐ Mental Illness	☐ STD	☐ Alzheimer's	☐ High Cholesterol
☐ Hepatitis B	☐ Alcohol Abuse	☐ COPD	☐ Neurologic Disease	☐ Arthritis - Osteo
☐ Hepatitis C	☐ Drug Abuse	☐ Lung Disease	☐ GERD/Reflux	☐ Arthritis - Rheum
☐ Anesthesia Issues	☐ Opioid Dependence	☐ Asthma	☐ Liver Disease	☐ Gout
☐ Blood Clots/DVT	☐ Heart Disease	☐ Stroke/TIA's	☐ Renal Failure	☐ Osteoporosis
☐ Cancer:_____	☐ High Blood Press.	☐ Neuropathy	☐ Kidney Disease	☐ Fibromyalgia
☐ Depression	☐ Vascular Disease	☐ Seizures	☐ Thyroid Disease	☐ MS
☐ Anxiety	☐ Diabetes Type____	☐ _____	☐ _____	☐ _____

Past Surgical History

Please list all prior surgical procedures and year ☐ None

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Social History

Alcohol use ☐ Never ☐ Quit ☐ I drink _____ drinks ☐ Daily ☐ Weekly ☐ Monthly

Tobacco use ☐ Never ☐ I quit smoking _____ packs/day in year _____ ☐ I smoke _____ packs ☐ Daily ☐ Weekly

Recreational drug use ☐ Never used recreational drugs or misused prescription drugs ☐ I have misused prescription drugs_____

☐ I have misused recreational drugs_____ ☐ I currently use _____ ☐ Daily ☐ Occasionally

Medications

Pharmacy name: _____Phone Number:_____

Non-prescription medications and supplements that you use more than one time per week ☐ None

☐ Tylenol ☐ Advil/Ibuprofen ☐ Alleve/Naproxen ☐ Aspirin ☐ Cough Medicine ☐ Decongestant ☐ Steroid Creams ☐ Vitamins

☐ Supplements (list) _____

List all medications that you take regularly or frequently. Include drugs, supplements and vitamins not listed above. ☐ None

Medication	Dosage	Reason you are taking

Allergies

Please list known allergies to drugs or substances ☐ None

Drug or Substance	Describe what happened	Year

Hospitalizations

Please list all prior hospitalizations, do not list normal pregnancies.

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Injuries

Please list all serious injuries requiring medical attention (broken bones, head or spine injuries, dislocations, etc…) include year.

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Review of Systems

Please check all that apply

- ☐ Unexpected Weight change
- ☐ Fever/Chills
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Feeling Down
- ☐ Mood Change
- ☐ Anger
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Heart Racing
- ☐ Pain with deep breath
- ☐ Wheezing
- ☐ Tremor or shaking
- ☐ Recents falls
- ☐ Rash
- ☐ Breast Lump
- ☐ Nail deformity
- ☐ Heartburn
- ☐ Blood in stool
- ☐ Constipation
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Hair loss
- ☐ Muscle cramps
- ☐ General weakness
- ☐ Morning stiffness
- ☐ Appetite change
- ☐ Hearing Loss

Family History

Please check all problems that any blood relatives have had. List relation.

- ☐ Alcohol/Drug Abuse_____
- ☐ Alzheimer's/Dementia_____
- ☐ Anemia_____
- ☐ Anesthesia Problems_____
- ☐ Aneurysm_____
- ☐ Asthma_____
- ☐ Arthritis-Rheumatoid_____
- ☐ Arthritis-Osteo_____
- ☐ Blood Clots/DVT_____
- ☐ Cancer, type_____
- ☐ Depression_____
- ☐ Diabetes/Type_____
- ☐ Gout_____
- ☐ Heart Disease_____
- ☐ High Cholesterol_____
- ☐ High Blood Pressure_____
- ☐ Kidney Disease_____
- ☐ Mental Illness_____
- ☐ Obesity_____
- ☐ Osteoporosis_____
- ☐ Stroke/TIA's_____

Relation	Age	State of health	If deceased, cause of death	Age at death
Father				
Mother				
Siblings				
Spouse				
Children				

By signing below, I hereby certify that the best of my knowledge all the information I have furnished on this form is complete, true, and accurate.

Patient / Legal Guardian Signature _____ Date _____

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PATIENT NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be disclosed. Please review it carefully.

Eaton Orthopaedics, LLC will use your medical information for the following:

1. TREATMENT: Including providing your medical records to consulting clinicians and insurance companies.

2. PAYMENT: We will file necessary claims to insurance companies in your name to obtain payment. They may request part or all of your medical record(s) to pay the claim.

3. HEALTH CARE OPERATIONS: Any others involved in your healthcare.

The entire PRIVATE POLICY NOTICE of Eaton Orthopaedics, LLC, is posted in the waiting room for your perusal.

QUESTION #1, 2, AND #3 MUST BE COMPLETED

In conjunction with these practices you will need to provide us with the following information:

1. **Name of person(s) we may speak to regarding your health**
   (i.e. spouse, child, etc. Including phone number)

   _____

   _____

   _____

2. **Emergency Contact: (relative not living with you)**

   Name: _____

   Address: _____

   Phone Number: (_____) _____

3. **May we leave a message regarding your health or upcoming appointments on your answering machine?**

   (Home) **Yes:**_____ **No:**_____

   (Work) **Yes:**_____ **No:**_____

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name or Legal Guardian Patient's Date of Birth

Koco Eaton, M.D. – *Sports Medicine, Orthopaedic Surgery*
Douglas Carlan, M.D. – *Hand and Upper Extremity, Orthopaedic Surgery*
900 Carillon Parkway, Suite 311
St. Petersburg, FL 33716
Phone (727) 573-KOCO
Fax (727) 573-5627

PATIENT INFORMATION RECORD

Patient Name_____ Email Address _____
First Middle Last

Street Address_____ Apt #_____ City_____ State_____ Zip_____

Out of State Address_____ Apt #_____ City_____ State_____ Zip_____

Date of Birth_____/_____/_____ Age_____ Gender ☐ M ☐ F Marital Status ☐ S ☐ M ☐ W ☐ D ☐ Sep

Social Security Number_____-_____-_____ Cell Phone _____ Home Phone_____

This information is **required** by the State of Florida and will be reported to the Agency for Health Care Administration. **http://ahca.myflorida.com**

Please complete the following:
☐ African American ☐ Asian ☐ Alaskan Native ☐ Hispanic ☐ Multiracial ☐Native American ☐ Other
☐ Pacific Islander ☐ Patient Declined ☐ Unknown by Patient ☐ White

Language:
☐ Cantonese ☐ English ☐ French ☐ German ☐ Indie ☐ Italian ☐ Japanese ☐ Mandarin
☐ Portuguese ☐ Russian ☐ Spanish ☐ Vietnamese ☐ Other

Occupation_____ Employer_____ Phone_____

Street Address_____ Suite_____ City_____ State_____ Zip_____

Patients Primary Doctor_____ Phone _____

Street Address_____ Suite_____ City_____ State_____ Zip_____

Referred by _____ Phone _____

Spouse (or Parent, if minor) _____
First Middle Last

Date of birth _____/_____/_____ Social Security Number _____-_____-_____ Phone _____

Street Address_____ Apt # _____ City_____ State_____ Zip_____

Occupation_____ Employer_____ Phone_____

Street Address_____ Suite_____ City_____ State_____ Zip_____

Emergency Contact _____ Relationship_____ Phone _____

Street Address_____ Apt #_____ City_____ State_____ Zip_____

Primary Insurance Company _____ Phone _____

Street Address_____ Suite_____ City_____ State_____ Zip_____

ID #_____ Policy # _____ Group #_____

Policy Holder's Name **(Required)**_____ Date of birth **(Required)**_____/_____/_____

Policy Holder's Address (if other than patient's): Phone _____ Relationship to Patient _____

Street Address_____ Apt #_____ City_____ State_____ Zip_____

Policy Holder's Employer (if other than patient's): _____ Phone _____

Street Address_____ Suite_____ City_____ State_____ Zip_____

Other Insurance Company _ _____ Phone _____

Street Address_____ Suite_____ City_____ State_____ Zip_____

ID #_____ Policy # _____ Group #_____

Policy Holder's Name **(Required)**_____ Date of birth **(Required)**_____/_____/_____

Policy Holder's Address (if other than patient's): Phone _____ Relationship to Patient _____

Street Address_____ Apt #_____ City_____ State_____ Zip_____

Policy Holder's Employer (if other than patient's): _____ Phone _____

Street Address_____ Suite_____ City_____ State_____ Zip_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS I authorize payments of medical benefits to the provider of services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account SHOULD BE REFERRED TO A COLLECTION AGENCY, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

_____ _____ _____

Responsible Party Signature Relationship Date

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PRESCRIPTION DRUG POLICY

The law requires responsible usage of prescription drugs by physicians and patients. If you accept a prescription from one of our physicians, you are also accepting responsibility to use the drug for yourself and only as prescribed. Our responsibility is to prescribe medications in appropriate dosages and amounts, with clear instructions. We will also inform you of the reason we are prescribing the drug, the expected benefits from its use and the major precautions and side effects. We will answer any questions you may have about the prescription drug you are being given.

Prescription drugs have potential for abuse and are regulated closely by state and federal agencies. Certain more closely controlled drugs (narcotic pain medications and tranquilizers) require even more responsibility on your part. We will accept **NO** excuses for their loss or theft and will not order replacements. We will not prescribe them if you are using them other than exactly as prescribed or receiving them from another source. We expect you to notify our office if you change drug stores or are getting medication from another source, so we may discontinue your prescription.

Many prescriptions drugs are appropriate for short-term use only. If and when we feel it is not in your best interest to continue a medication, we will tell you. If we cannot agree about your continued use of a substance, then we will require additional consultation with other specialists to help decide on the correct course of action.

Our office also requires a 24-48 hour call-in policy for the refill of your prescriptions. When your medications are getting low and you feel you need a refill, please call our office with the name of your pharmacy and pharmacy phone number 24 to 48 hours prior so that we will have ample time to ask your treating physician and call your medication in to your pharmacy.

Failure to follow these policies will force our office to terminate our professional relationship with you and may require us to file a report with the Department of Professional Regulation (DPR) or the local police.

If you are in agreement with all of the information as provided above, please sign below that you agree to abide by these policies.

SIGNED:

_____
Patient/Guardian Signature & Date

Pharmacy Name:_____

Street Address:_____ City_____ State_____ Zip_____

Phone No.:_____

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Patient Financial Policy – Insured

Thank you for choosing Eaton Orthopaedics, LLC. Due to patient questions regarding their payment vs. insurance responsibility for services rendered, we have developed this financial policy. We encourage you to ask us any questions you may have about our policy.

Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan that we currently accept, or you do not have a valid insurance card, you are welcome to take advantage of our self pay rates.

Co-Payments and Deductibles: *All co-payments and deductibles must be paid in full at the time of service.* This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from our patients can be considered fraud. Please help us uphold our agreement with your insurance company by paying your co-payment and/or deductible at each visit.

We always collect the ***anticipated*** office visit portion of your visit at check-in. This estimated fee amount **only** covers your time with the physician and/or any radiology needed. There are instances where additional, or less, time is required than anticipated and the actual fee will be adjusted when the claim is paid by your insurance company and a refund will be issued.

Non-Covered Services: Please be aware that some, and perhaps all, of the services you receive may not be covered or considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Proof of Insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your valid driver's license and current valid insurance card as proof of insurance. If you fail to provide us with the correct insurance information in a timely manner you may be responsible for the balance of your claim.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company since we are not party to that contract.

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If you do not provide us with the correct insurance information in a timely manner, you will be responsible for the entire balance.

Nonpayment: If your account is over 120 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise arranged. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Outstanding Balances: It is your responsibility to keep your account with us current. This includes all outstanding balances due resulting from co-pays, deductibles, non-covered services, billing adjustments, etc. that are reflected in your Explanation of Benefits received from your insurance company and billing statements received from us. You must pay these outstanding balances in full prior to seeing the physician for your next appointment. **Non-receipt of a statement(s) from us does not excuse your obligation to pay your outstanding balance.**

_____ _____
Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____
Print Patient's Name or Legal Guardian | Date