

Atlas Orthopedics And Sports Medicine

7975 Lake Underhill Rd., Ste 330

Orlando, FL 32822

(407) 381-8441

PATIENT INFORMATION							
NAME (LAST, FIRST, MIDDLE)			MRN	SSN#		BIRTHDATE	SEX
LOCAL ADDRESS		CITY , STATE, ZIP			SECONDARY BILLING ADDRESS		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		REFERRING PHYSICIAN		CITY, STATE, ZIP	
MARITAL STATUS	STUDENT STATUS FULL TIME _____ PART TIME _____	SMOKER(Y/N)?	VETERANY(N)?	PRIMARY CARE PROVIDER		HOME PHONE	
PRIMARY EMPLOYER				SECONDARY EMPLOYER (IF APPLICABLE)			
ADDRESS				ADDRESS			
CITY, STATE, ZIP				CITY, STATE, ZIP			
WORK PHONE				WORK PHONE			

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)							
NAME (LAST, FIRST, MIDDLE)			SSN#		BIRTHDATE	SEX	
LOCAL ADDRESS		CITY , STATE, ZIP			SECONDARY BILLING ADDRESS		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE, ZIP			
MARITAL STATUS	STUDENT STATUS	SMOKER(Y/N)?	VETERANY(N)?	PRIMARY CARE PROVIDER		HOME PHONE	
RELATIONSHIP TO PATIENT							

PRIMARY INSURANCE				
NAME OF INSURANCE COMPANY			POLICY #	
NAME OF INSURED			GROUP #	
ADDRESS OF INSURANCE COMPANY			COPAY AMOUNT	
CITY, STATE, ZIP		PHONE	\$	
RELATIONSHIP TO PATIENT			DEDUCTIBLE	
			\$	
			EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (IF APPLICABLE)				
NAME OF INSURANCE COMPANY			POLICY #	
NAME OF INSURED			GROUP #	
ADDRESS OF INSURANCE COMPANY			COPAY AMOUNT	
CITY, STATE, ZIP		PHONE	\$	
			\$	
			EFFECTIVE DATE	EXPIRATION DATE

I authorize payment of medical benefits to Atlas Orthopedics and Sports Medicine for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my contract. I also authorize you to release, to my insurance company or their agent, information concerning health care, advise, treatment or supplies provided to me. This information will be used fro the purpose of evaluating and administering claims for benefits.

NAME

DATE

Atlas Orthopedics and Sports Medicine

Sean M. McFadden, D.O.

Any unanswered questions represent a "NO" answer

Name: _____ Date Of Birth: _____

Reason for Visit : _____

Is the reason for your visit due to an injury or accident? Yes NO

Was the accident: Work Related Auto related Other, Specify place _____

Date and time of accident: _____

Were X-rays taken of this injury or problem? Yes No

If yes, When & Where were X-rays taken? _____

Emergency Contact

Name: _____ Ph. _____ Relationship _____

Personal History: Do you have or have you ever had any of the following conditions:

	NO	YES	TYPE	Year or Age Diagnosed
Arthritis				
Asthma				
COPD				
Diabetes				
Cancer				
GI Disease				
Heart Disease				
High Blood Pressure				
Problems with Anesthesia				
Osteoporosis				
Stroke				
Thyroid Disease				
Other				

Surgical History - Please specify surgical procedure to the best of your knowledge.

Procedure (s) and Date (s)

Medications (Drug Name and Dose) See list provided (if applicable)

Do you smoke? Yes No How many packs per day? _____ How long? _____

Do you Drink Alcohol? Yes No How much/frequency: ___daily ___week ___socially

Have you ever used illicit/street drugs? Yes No _____

****List the names of the people with whom we can discuss your care
(Family, friends, other physicians, employers, attorneys)**

Atlas Orthopedics and Sports Medicine
Sean M. McFadden, D.O.

Name: _____ Date Of Birth: _____

Review of Symptoms

(Please Circle all that Apply)

Do you have or have you ever had any of the following problems:

CONSTITUTIONAL

Chills	Yes	No
Fatigue	Yes	No
Fever	Yes	No
Malaise	Yes	No
Night Sweats	Yes	No
Weakness	Yes	No
Weight Gain	Yes	No
Weight loss	Yes	No

CARDIOVASCULAR

Chest Pain	Yes	No
Cyanosis	Yes	No
Heart Murmur	Yes	No
Hypertension	Yes	No
Irregular Heartbeat	Yes	No
Leg Swelling	Yes	No

INTEGUMENTARY

Contact Allergy	Yes	No
Itchy Skin	Yes	No
Rash	Yes	No
Skin Infections	Yes	No
Skin Lesion	Yes	No

METABOLIC/ENDOCRINE

Cold Intolerant	Yes	No
Hair Loss	Yes	No
Heat Intolerant	Yes	No

HEENT

Blurred Vision	Yes	No
Double Vision	Yes	No
Difficulty Swallowing	Yes	No
Ear Drainage	Yes	No
Facial Pain	Yes	No
Headache	Yes	No
Hearing Loss	Yes	No
Hoarseness	Yes	No
Nasal Congestion	Yes	No
Ringing in ears	Yes	No
Vertigo	Yes	No
Vision Loss	Yes	No

GASTROINTESTINAL

Abdominal Pain	Yes	No
Constipation	Yes	No
Black Tarry Stools	Yes	No
Diarrhea	Yes	No
Heartburn	Yes	No
Jaundice	Yes	No
Loss of Appetite	Yes	No
Nausea	Yes	No
Vomiting	Yes	No

NEUROLOGICAL

Difficulty Walking	Yes	No
Dizziness	Yes	No
Poor Coordination	Yes	No
Memory Loss	Yes	No
Muscle Weakness	Yes	No
Paresthesia	Yes	No
Seizures	Yes	No
Tremors	Yes	No

PSYCHIATRIC

Anxiety	Yes	No
Depression	Yes	No
Insomnia	Yes	No

HEMATOLOGIC

Bleeding	Yes	No
Bruising	Yes	No

RESPIRATORY

Chest Pain (Respiratory)	Yes	No
Cough	Yes	No
Dyspnea (Shortness of Breath)	Yes	No

GENITOURINARY

Dysuria (painful urination)	Yes	No
Frequent Urination	Yes	No
Hematuria (Blood in urine)	Yes	No
Urge Incontinence	Yes	No

Atlas Orthopedics and Sports Medicine
Sean M. McFadden, D.O.

Name: _____ Date Of Birth: _____

Review of Symptoms (Cont.)
(Please Circle all that Apply)

MUSKULOSKELETAL

Back Pain	YES	NO
Bone/Joint symptoms	YES	NO
Myalgias	YES	NO
Muscle Weakness	YES	NO
Neck Stiffness	YES	NO
Rheumatologic Manifestations	YES	NO

IMMUNOLOGICAL

Asthma	YES	NO
Bee Sting Allergies	YES	NO
Contact Dermatitis	YES	NO
Food Allergies	YES	NO
Seasonal Allergies	YES	NO

****Pharmacy name and phone number for electronic prescriptions:**

Family History

	NO	YES	Relation (Father, Mother, Sibling, Other)	Type	Year or Age Diagnosed
Arthritis					
Asthma					
COPD					
Diabetes					
Cancer					
GI Disease					
Heart Disease					
High Blood Pressure					
Problems with Anesthesia					
Osteoporosis					
Stroke					
Thyroid Disease					
Other					

Please list all drug allergies:

Communication use & disclosure authorization. You may contact me regarding treatment and care at the following:

Phone: _____ E-mail: _____

Payment Policy

***Medicare co-payments and deductibles.** For 2010, the Medicare Part B deductible is 155.00. Payment of this deductible and your 20% co-payment of the Medicare allowable fee will be expected at the time of your visit.

***Commercial Insurance co-payments and deductibles.** If you have commercial insurance, payment of your co-payment and/or any outstanding annual deductible will be expected on the day of your visit. Should your insurance have a 10% or 20% co-insurance, this payment will be expected at the time of your visit. As we are contracted with most of the major payers, our fees are adjusted to the allowable fee as per the payer's contract. Our practice accepts Cash, or Master Card and Visa should you prefer to pay by charge card.

***Self Pay patients.** For new patients, a \$300.00 deposit is required to be paid prior to your visit at check in. Should your actual services received total more than \$300.00, the balance will be due at the completion of your visit today.

***Automobile (PIP) Claims.** Prior to your visit, there is an information packet that will need to be completed in order for us to be able to file your automobile claim. Many automobile carriers will only reimburse 80% of your expenses. The 20% of your expenses that will not be paid by your automobile carrier will be expected on the day of your visit. We do not accept Letters of protection (LOP's) and we do not bill to third parties, that is the patient's responsibility.

***Paperwork Expenses.** Dr. McFadden is happy to assist you with the completion of necessary employment and credit related claim forms (FMLA forms, Disability forms, etc). Our fee for the completion of your form is \$30.00 per form. Should you or your attorney request a copy of our medical records regarding your treatment with us, our fee is \$1.00 per page. Payment for the completion of forms or medical records is required prior to the release of the paperwork. Please allow 7 to 10 business days for your request to be completed.

***Patient's responsibility:** Our policy states that as a courtesy to our patients, we submit their claims to their insurance companies as a way of helping them ensure the payments are sent for the services that are rendered. The patient is responsible for claims denied for any of the following reasons: incorrect insurance information, wrong ID numbers, or incorrect claims address. Ultimately it is the patient's responsibility for payment of services that are rendered.

***24 Hour Notice.** I understand that if I do not give the required **24 Hour Notice** to cancel my appointment that I will be charged a No Show fee of \$35.00.

***Privacy Practices.** By initialing this, I acknowledge that I am in receipt of Atlas Orthopedics & Sports Medicine's Notice of Patient Privacy Practices. _____

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Our practice accepts Cash, or Master Card and Visa should you prefer to pay by charge card.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

SIGNATURE

DATE