

ATLANTIC ORTHOPAEDIC GROUP

HOMI COOPER, MD

1341 Medical Park Drive, Suite 201

Melbourne, FL 32901

PATIENT INFORMATION

Please Print Clearly

Name: (FIRST, MIDDLE, LAST) _____

Address: _____ City: _____

State: _____ Zip Code: _____ Date of Birth: _____ Age: _____

Sex: M/F Marital Status: M/S/D/W Social Security Number: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Work Phone: _____

Spouse Name: _____ Spouse's Employer: _____

Spouse's Work Phone: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact's Phone#: _____

Family Physician: _____ Phone #: _____

How Did You Select Us? _____

Insurance Information

Primary Insurance: _____ Policy ID #: _____

Group #: _____ Policy Holder Name: _____

Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance: _____ Policy ID #: _____

Group #: _____ Policy Holder Name: _____

Date of Birth: _____ Relationship to Patient: _____

ATLANTIC ORTHOPAEDIC GROUP

**AUTHORIZATION FOR INSURANCE ASSIGNMENTS
AND
RELEASE OF INFORMATION**

1. **Release and Use of Information.** I, the undersigned patient, do hereby authorize Atlantic Orthopaedic Group, P.A., its physicians, paraprofessional and administrative staff to receive, release, disclose and use any medical, psychiatric or drug-related records and information concerning my diagnosis and treatment for purpose of treatment, payments and healthcare operations as defined in 45, C.F.R. & 164.501. Any such records and information may be received from or disclosed to any other healthcare provider involved in my case and any third party payor (such as an insurance company, employer, or governmental agency). A copy of this authorization may be used in place of the original.

2. **Physician Insurance Assignment.** I hereby authorize payment of medical benefits for services provided by any employee of Atlantic Orthopaedic Group, P.A. to be made directly to Atlantic Orthopaedic Group, P.A.

3. **Duration.** This authorization shall remain in effect during my lifetime. I may revoke this authorization at any time by delivering a written notice to Atlantic Orthopaedic Group, P.A.

4. **Insurance.** I acknowledge that Atlantic Orthopaedic Group, P.A. files insurance claims on my behalf as a courtesy. If my insurance fails to pay for any reason within thirty (30) days after my visit, I am responsible for payment in full. Co-payments and deductibles are due at the time of visit.

Date of Birth: ____/____/____

Social Security #: _____ - _____ - _____

Signature: _____ **Date:** _____

Printed Name: _____



1341 Medical Park Drive, Suite 201 • Melbourne, FL 32901
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**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS**

NAME _____

BIRTHDATE _____ SOCIAL SECURITY # _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.
- An authorization to leave medical information on the contact numbers provided.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to care out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my healthcare information:

PATIENT:

X _____
Signature of Patient or Legal Representative Date Witness Signature

ATLANTIC ORTHOPAEDIC GROUP
1341 MEDICAL PARK DRIVE, SUITE 201
MELBOURNE, FL 32901

WELCOME TO ATLANTIC ORTHOPAEDIC GROUP. IT IS NECESSARY TO COMPLETE THE ATTACHED FORMS PRIOR TO YOUR EVALUATION WITH DR. HOMI COOPER.

PLEASE CAREFULLY COMPLETE THE **SHADED** AREAS **ONLY**. IT IS VERY IMPORTANT THAT YOU **PRINT LEGIBLY** USING INK, AS THIS WILL BECOME PART OF YOUR PERMANENT MEDICAL RECORD.

IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE IN COMPLETING THESE FORMS, PLEASE FEEL FREE TO ASK.

THANK YOU,

DR. HOMI COOPER AND STAFF

**ATLANTIC ORTHOPAEDIC GROUP
HOMI S. COOPER, MD**

DATE OF EXAM: _____

PATIENT NAME: _____ **DOB:** ___/___/___ **AGE:** ___
HEIGHT: ___ ft. ___ in.
WEIGHT: ___ lbs.

- Right hand dominant**
- Left hand dominant**
- Ambidextrous**

BP _____ **TEMP** _____

REFERRING PHYSICIAN: _____

DATE OF INJURY: ___/___/___

OCCUPATION: _____
(also, if retired, please list pre-retirement occupation)

Name of Employer: _____

Job Position: _____

Length of time at this position: _____

Length of time at this company: _____

CHIEF COMPLAINT:

Give a detailed description of how your injury happened:

HISTORY OF PRESENT ILLNESS:

How long have you had this problem? _____ Days
_____ Weeks
_____ Months
_____ Years

Is your complaint(s) related to a:

- (a) Workers' Compensation claim? No Yes
- (b) Motor vehicle accident? No Yes
- (c) Personal injury? No Yes

Is there an attorney involved? No Yes

Name of attorney _____

Were you seen in the Emergency Room for your complaint?

No Yes, Date: _____ Were x-rays taken? No Yes

Were medications prescribed? No Yes,
Name of medications: _____

Did another physician treat you for your complaint?

No Yes, Physician: _____ Date: _____

Have you had prior diagnostic studies for your complaint?

No Yes, Type of study: _____

(for example, x-ray, MRI, EMG)

Where? _____ Date: _____

PAST MEDICAL HISTORY

Have you had this or a similar condition at any time in the past? (Describe in detail)

PREVIOUSLY DIAGNOSED MEDICAL PROBLEMS

| DIAGNOSIS | YES | NO | Explanation |
|--|------------|-----------|--------------------|
| Cancer | | | |
| Head Trauma/Seizure Disorder | | | |
| Headaches | | | |
| Stroke | | | |
| Multiple Sclerosis | | | |
| Depression | | | |
| Ears/Nose/Throat Problems | | | |
| Thyroid Problems | | | |
| High Blood Pressure | | | |
| Heart Problems | | | |
| Sleep Apnea | | | |
| High Cholesterol | | | |
| Breathing/Lung Problems | | | |
| Kidney/Bladder/Urinary Problems | | | |
| Stomach/Bowel/Colon Problems | | | |
| Liver Problems/Hepatitis | | | |
| Diabetes | | | |
| Skin Conditions | | | |
| Arthritis | | | |
| Osteoporosis | | | |
| Fractures | | | |
| Gout | | | |
| Edema | | | |
| Vascular Disease | | | |
| Other | | | |

REVIEW OF SYSTEMS

(If symptoms below apply to you, check either Current, Past or Both)

| SYMPTOM | Current Problem | Problem in Past | Explanation |
|--|-----------------|-----------------|-------------|
| Headaches | | | |
| Blurred or Double Vision | | | |
| Ringing in the Ears | | | |
| Runny Nose | | | |
| Hearing Problems | | | |
| Sore Throat | | | |
| Hoarseness | | | |
| Shortness of Breath | | | |
| Chest Pain | | | |
| Bleeding Problems | | | |
| Circulation Problems (cold or discolored extremities) | | | |
| Heartburn | | | |
| GI/Bowel Problems | | | |
| Abdominal Pain | | | |
| Blood in the Stool | | | |
| Vomiting Blood | | | |
| Urinary Infection | | | |
| Painful Urination | | | |
| Urinary Incontinence | | | |
| Incontinence of Stool | | | |
| Frequent Urination | | | |
| Leg Swelling | | | |
| Weakness | | | |
| Skin Problems | | | |
| Dizziness/Symptoms of Stroke (TIA) | | | |

PAST SURGICAL HISTORY/HOSPITALIZATIONS

(please list all surgeries in your lifetime)

| PROCEDURE | YEAR | PROCEDURE | YEAR |
|-----------|-------|-----------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

CURRENT MEDICATIONS

| Name | Dose | Frequency | Name | Dose | Frequency |
|-------|-------|-----------|-------|-------|-----------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

ALLERGIES

| MEDICATION | REACTION | MEDICATION | REACTION |
|------------|----------|------------|----------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

SOCIAL HISTORY

Do you smoke? Yes Quit Never

If the answer is Yes or Quit, please list:

When did you quit? _____ Maximum number of packs per day? _____
Total number of years? _____

Do you chew tobacco? Yes Quit Never

If the answer is Yes or Quit, please list:

When did you quit? _____ Maximum amount per day? _____
Total number of years? _____

Do you drink alcohol? No Yes, Number of drinks per week? _____

(including beer or wine) Type of alcohol? _____

Are you a recovering alcoholic? No Yes

Marital Status Single Married Divorced

Number of children _____

Number of children living with you? _____

Ages of children? _____

FAMILY MEDICAL HISTORY

Using the list from Past Medical History (on page 2), please describe any medical history that runs in your immediate family. (for example, father – cancer, diabetes)

FATHER: _____

MOTHER: _____

BROTHER(S): _____

SISTER(S): _____

CHILDREN: _____

Reviewed by Homi S. Cooper, MD _____ Date: _____