

ATLANTIC ORTHOPAEDIC GROUP

John Hermansdorfer, 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
LIFETIME AUTHORIZATION FOR INSURANCE ASSIGNMENTS AND
RELEASE OF INFORMATION**

Release of Information: I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third-party payer (such as an insurance company or governmental agency, example: Blue Cross Blue Shield or Medicare) any medical, psychiatric, or alcohol or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment.

Physician Insurance Assignment: I, the below named patient, hereby authorize payment of medical benefits for services provided by any physician of Atlantic Orthopaedic Group to be made directly to the physician/group.

I permit a copy of these authorizations to be used in place of the originals. These authorizations will be in effect until revoked by me in writing.

Please remember we file insurance as a courtesy to our patients. If for some reason your insurance fails to pay for your services, you will be responsible for payment.

Financial Policy: Atlantic Orthopaedic Group will file your primary insurance as a courtesy. Your co-pay and deductible is due at the time of visit. If your insurance company doesn't pay within 30 days, or if your claim is denied it will be due and payable immediately.

Physician Assistant: Dr. John Hermansdorfer employs a certified physician assistant in his practice. By signing below, I am agreeing to treatment by this practitioner as my physician deems necessary.

Date of Birth: ____/____/____ **Social Security Number:** ____-____-____

Signature _____ **Date** _____

Printed Name _____



1341 Medical Park Drive, Suite 201 • Melbourne, FL 32901
TEL: (321) 768-9914 • Fax: (321) 722-0070

**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. JOHN HERMANSDORFER.

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. JOHN HERMANSDORFER AND STAFF

ATLANTIC ORTHOPAEDIC GROUP

JOHN HERMANDSORFER, MD

PATIENT NAME: _____ **DOB:** ___/___/___ **HEIGHT:** ___ft. ___in.
WEIGHT: ___ lbs. **(Month/ Day/ Year)**
AGE: _____
REFERRING PHYSICIAN: _____

CHIEF COMPLAINT: (Give a brief description of the nature of your visit – for example: Left foot pain)

HISTORY OF PRESENT ILLNESS:

Give a brief description of your injury: _____

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

If known, give the exact date this actually began:

(as in a work-related injury or motor vehicle accident) _____/_____/_____
(Month/ Day/ Year)

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 medication: _____

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:** _____

DESCRIBE YOUR PAIN:Severity: Mild Moderate SevereQuality: Dull Sharp Aching ThrobbingDuration: Intermittent Constant Night Day

Made better by: _____

Made worse by: _____

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			

PAST SURGICAL HISTORY

(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

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

Do you smoke? Yes Quit Never

If the answer is Yes or Quit, please list:

Maximum number of packs per day? _____

Total number of years? _____

Do you drink alcohol? No Yes,

Number of drinks per week? _____

Type of alcohol? _____

FAMILY 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): _____

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)			

Reviewed by John Hermansdorfer, MD _____ Date: _____