Patient Registration

Please Complete All

Date / /	

Patient Name Last First Initial	Marital Status ☐S ☐M ☐D ☐W	Sex ☐M ☐F
Home Address	City, State, Zip	Telephone
Occupation	Social Security Number	Date of Birth / /	Age	Email Address
Spouse or Parent Name	Employer's Name and Address	Work Telephone

Name of Financially Responsible Person (if Different from Patient) **MUST BE PERSON SIGNING FORM** ☐ Spouse ☐ Parent ☐ Other		
Address (if Different from Patient)	Date of Birth	Social Security Number
Employer Name and Address	Telephone	Work Telephone

If Minor, name of other parent:		
Address of other parent:	Date of Birth	Social Security Number
Employer Name and Address	Telephone	Work Telephone

Primary Health Insurance Co. Name		Policy Holder	Policy Holder's Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other	
Insurance Co. Address (not necessary if card was copied)	ID/Policy No.	Group No.	Policy Holder DOB	Effective Date / /
Secondary Health Insurance Co. Name		Policy Holder	Policy Holder's Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other	
Insurance Co. Address (not necessary if card was copied)	ID/Policy No.	Group No.	Policy Holder DOB	Effective Date / /
Emergency Contact	**Relationship to Patient**		**Telephone**	

Your Current Problem: Work Related? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No Other Accident? ☐ Yes ☐ No		
Date of Injury/Accident / /	**Brief description of accident: (Where you were? How it happened?)**	
Employer at Time of Injury	Address	Telephone
Description of Injury:		

Workers' Compensation Insurance Carrier	Claim Number

If you are providing motor vehicle for payment, please provide your private health information to be filed for the remaining portion of the charges.

AUTHORIZATION AND RELEASE:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to my attorney, third party payers, and/or other health practitioners. **I authorize and request my insurance company to pay Provident Orthopedic and Sports Medicine Center directly for services rendered and billed by them.** I understand that the filing of insurance claims is a courtesy of Provident Orthopedic and Sports Medicine Center. I remain fully responsible for any charges incurred. I further agree that understanding my insurance benefits is my responsibility. Should I have any questions regarding my insurance my best avenue is calling my insurance company benefits department. I agree to be fully responsible for any fees incurred to collect any outstanding balance up to and including interest charges (up to 10%) and any court/sheriff fees used in attempt to collect any overdue debt. I understand that payment of copays/coinsurance may be requested to be paid prior to the full processing of my insurance claims. I authorize for detailed messages to be left on the phone numbers provided, unless noted otherwise. I further understand that the issuing of credit pending insurance payment is a courtesy and at the full discretion of Provident Orthopedic and Sports Medicine Center as payment is expected at the time service is rendered.

Signature of Patient/Legal Guardian if Minor Date

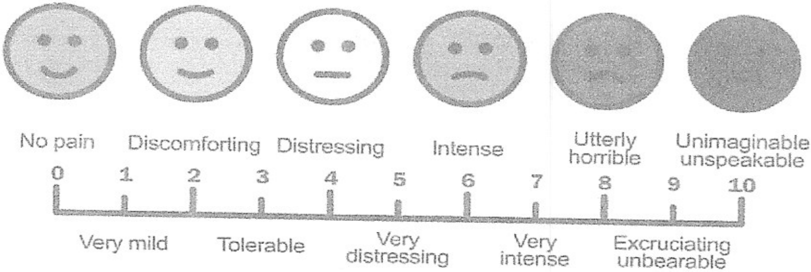
Patient Name: ____ Date of Birth ______/____/____

Current Problem:

How long have you had this problem?(specify a number) _____days ____weeks ____months ____years

How would you describe the pain? mild moderate severe stabbing throbbing

Please mark your pain on the pain scale:



What treatment have you had for this problem (circle all that apply)

Anti-inflammatory meds Injections Therapy Surgery No Treatment Other ____________________

Are you right handed __________ Are you left handed ____________

PAST MEDICAL HISTORY (Please mark all that apply to YOUR past medical history)

Alcoholism
Anemia
Arthritis
Bleeding Disorder
Cancer
Diabetes
Gout

Heart Trouble
High Blood Pressure
Kidney Problems
Lung Disease
Mental Illness
Phlebitis
Seizures

Stomach Ulcer(s)
Stroke
Thyroid Problems
Tuberculosis
Liver Problems
Other Illness/Injuries
Explain ____________________

Please list all past surgeries

____

____

Do you have any food, drug, metal, latex, or adhesive allergies? Please list all

____

____

Any other medical history we should be aware of? ____________________________________

____

Family Medical History (Please list all that apply to mother, father, brother, sister, children)

Alcoholism
Anemia
Arthritis
Bleeding Disorder
Cancer
Diabetes
Gout

Heart Trouble
High Blood Pressure
Kidney Problems
Lung Disease
Mental Illness
Phlebitis
Seizures

Stomach Ulcer(s)
Stroke
Thyroid Problems
Tuberculosis
Liver Problems
Other Illness/Injuries
Explain ____________________

Patient Name ______________________________ Date of Birth: ______________

Social History

Have you ever used alcohol products? Y N If yes, are you currently using? Y N
If currently using, please list frequency ______________________________
Have you ever used tobacco products? Y N If yes, are you currently using? Y N
If currently using, please list packs or cans per day ______________________________
Have you ever used illegal drugs? Y N If yes, are you currently using? Y N
If currently using, please list what and frequency ______________________________

*** Do you have an advanced care plan? Y N If yes, who is your designated surrogate? ______________

Who is your preferred pharmacy? ______________________________ Phone: ______________

Are you currently taking any medication? If so, please all:

Name	Dosage/Strength	How many per day

Do you have any of the following (please circle all that apply).

Pacemaker Aneurysm Clips Cochlear Implant Spinal Stim Implant

Other implants

WOMEN ONLY

Is there a chance that you are pregnant? Y N Last menstrual cycle end date ______/______/______

I attest that the above information is true and accurate.

____

Signature Date

HIPAA receipt:
I have been made aware of the HIPAA policy that was effective July 1, 2019. I have been offered a copy of the policy if I wish. Additionally, I am aware that the policy is posted on the wall with available copies if I choose take one in the future.

____

Patient/Guardian Signature Date

____

Printed Patient Name

No Show Policy:
Our office requires 24-hour notice for any appointment cancellations. Missed appointments will be subject to a $25 no show fee that will be payable at the next appointment. For your convenience, we have an answering machine so that cancellations after hours are still possible.

____

Patient/Guardian Signature Date

Name: ______________________

DOB: ______________

Chart: ______________

Provident Orthopedic and Sports Medicine Center Assignment and Lien for Medical Services Rendered

If I, ______________________, receive or become entitled to receive any monies from any source whatsoever for my injuries, either through a lawsuit, settlement of a lawsuit or claim, award by a court or arbitrator(s), jury verdict, judgment or payment of insurance proceeds, I hereby assign and agree to pay said funds to:

Provident Orthopedic & Sports Medicine Center, LLC
801 Marshall Farms Road Ocoee, FL 34761

to the extent of any outstanding amounts then owed by me to the Provident Orthopedic and Sports Medicine Center, LLC for medical services before any other fees, costs, or expenses are disbursed from any said funds. I further agree and acknowledge that the fee for the services to be performed by the Provident Orthopedic and Sports Medicine Center, LLC depends on the treatment rendered and that any amount that I owe to the Provident Orthopedic and Sports Medicine Center, LLC shall constitute a lien on any claim or lawsuit I may have as a result of my injuries and any settlement, judgment, jury verdict, or insurance proceeds that I receive or become entitled to receive.

This Assignment and Lien shall be placed in my chart and a copy thereof shall constitute actual notice to my attorney, or any other person, that my medical bills to the Provident Orthopedic and Sports Medicine Center, LLC shall be paid first from the proceeds of any such settlement, judgment, jury verdict, insurance proceeds or otherwise. This authorization cannot be modified unless it is in writing and signed by both parties.

I hereby appoint the Provident Orthopedic and Sports Medicine Center, LLC or its designee as my attorney-in-fact to sign my name to and file a financing statement under the Uniform Commercial Code to evidence this lien.

I understand that I remain personally responsible for the payment of all fees owed by me to the Provident Orthopedic and Sports Medicine Center, LLC and that notwithstanding this Assignment and Lien, the Provident Orthopedic and Sports Medicine Center, LLC is not required to look to any other person or entity for payment.

I hereby instruct my attorney to pay directly the Provident Orthopedic and Sports Medicine Center, LLC such sums as may be due and owing for medical services rendered to me, and to withhold such sums from any settlement, judgment, jury verdict, or insurance proceeds as may be necessary to adequately protect the Provident Orthopedic and Sports Medicine Center, LLC These instructions are irrevocable and may not be changed without the written agreement of the Provident Orthopedic and Sports Medicine Center, LLC I have given authorization to the Provident Orthopedic and Sports Medicine Center, LLC to forward this document to my attorney. My attorney hereby acknowledges that in the event I recover money through settlement, judgment, jury verdict, or insurance proceeds from any person or entity in which the law firm and/or attorney is an additional named payee, my attorney agrees to withhold and pay sufficient funds to the Provident Orthopedic and Sports Medicine Center, LLC for any outstanding expenses owed to the Provident Orthopedic and Sports Medicine Center, LLC in connection with medical services rendered as a result of my injuries.

______________________	______________________	__________
Print name of patient (or authorized representative)	Signature of patient (or authorized representative)	Date

Reason patient is unable to sign and representative's relationship to patient or authority to sign on behalf of patient

______________________	______________________	__________
Signature of Attorney	Print name of Attorney	Date