CENTRAL FLORIDA
BONE & JOINT INSTITUTE
1639 N. VOLUSIA AVENUE, ORANGE CITY, FL 32763
PHONE: 386-775-2012 FAX: 386-775-2013

Please present ALL INSURANCE CARDS and ID upon check-in.

Patient's Full name: _____

Date of Birth: _____ Gender: □ Male □ Female Height: _____ Weight: _____

Marital status: □ Single □ Married □ Divorced □ Widowed Race/ Ethnicity: _____

Address:_____

Apt : _____ City:_____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Email address: _____ Appointment Reminder: □ Text □ Call / □ Home □ Cell

Primary Care Physician:_____ Primary Care Physician #:_____

Referring Physician: _____ Referring Physician #: _____

Preferred Pharmacy:_____ Pharmacy Phone #: _____

Primary Ins:_____ Policy#:_____Group: _____

Secondary Ins:_____ Policy#:_____Group: _____

Is the patient the policy holder?: □ Yes □ No If not, what is the Policy holder name:_____

Policy Holders Date of Birth: _____ Relationship to Patient: _____

Emergency Contact: _____ Phone #: _____

If Patient is a minor please list Mother/Father/Guardian Information

Name: _____ Relationship to Patient_____ Phone Number: _____

Name: _____ Relationship to Patient _____ Phone Number: _____

Please be aware that you may receive a questionnaire from your insurance company regarding whether or not your visit(s) is Workers Compensation or Motor Vehicle Accident Related. In the event that you do not return the questionnaire to your insurance company, you will be solely responsible for all charges due to Central Florida Bone & Joint Institute. _____ (please initial)

Patient's or Authorized Person's Signature

I authorize the release of any medical or other information necessary to process my insurance claim. I authorize payment of medical benefits to my physician, Central Florida Bone & Joint Institute for services rendered to me. I understand I am responsible for all deductibles, co-pays, and non-covered services. I hereby acknowledge that I have read and completely understand the authorization above.

_____ _____ _____

Signature Name of Authorized Person (If other than patient) Date

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Problem/ Injury Info

Reason for visit: _____

Date of injury/accident: _____

If seen in E.R. which facility and Date: _____

Did you have any imaging done (Xray, MRI, CT etc.): _____

Please List your medications below. If you have a list of your own please provide it to the front desk for scanning

MEDICATION	DOSAGE	DATE STARTED

_____ _____

Patient Signature Date

CENTRAL FLORIDA
BONE & JOINT INSTITUTE

HIPAA Authorization Form

I, _____ give permission to Central Florida Bone & Joint Institute to disclose the following protected health information to (please list all authorized users):

_____

_____

Information to be disclosed (check all that apply):

☐ Medical Records ☐ Treatment Records ☐ Diagnostic Reports
☐ Other: _____

This protected health information is being used or disclosed for the following purposes:

_____

This authorization expires: _____ ☐ Does not expire

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending notification to 1639 North Volusia Avenue, Orange City, FL 32763.Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____ _____

Signature of participant or personal representative Date

_____

Relationship of personal representative