Florida Joint Care Institute
2165 Little Road, Trinity, FL 34655
Phone (727)372-6637 Fax (727)375-5044
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Thank you for choosing Florida Joint Care Institute for your orthopedic needs. We have prepared a packet of information and forms to make your visit with us an efficient and pleasant experience. We ask that you complete the attached paperwork in its entirety and legibly.

When you come for your appointment please bring the following, without any of the following we will not be able to keep your scheduled appointment:

- ✓ Completed new patient paperwork
- ✓ Current Medical Insurance Cards (Medicare, primary provider, secondary provider, etc.)
- ✓ A complete list of ALL medications including strengths and dosage
- ✓ Photo ID: Driver's license or state issued ID
- ✓ X-Rays and MRI's. If you have any imaging pertaining to the body party our office will be treating, please be sure to bring those with you.

Please be prepared to pay via credit/debit card or cash for the following at the time of your visit:

- ✓ Co-payments. If your insurance requires co-payment you are responsible for this at the time of your appointment.
- ✓ Co-insurance and deductible. If your insurance requires a co-insurance or deductible, you are responsible for that at the time of your appointment.
- ✓ If you do not have insurance, payment will be collected at time of service.

Referrals/Authorizations: Most insurance requires referral/authorization from your primary care physician.

Please be sure to contact your primary care physician and let them know that they will need to fax the referral/authorization to (727)372-6637 at least 48 hours prior to your appointment. Without this referral/authorization 48-hours prior to your appointment, we will need to reschedule you. If you do not have a primary care physician and your insurance requires a primary care physician referral, you will need to establish with a primary care physician before we will be authorized to see you.

Please be sure to check-in 15 minutes prior to you scheduled appointment time to allow our staff to complete the administrative portion of your appointment.

No show fee of $25 is assessed if a patient does not call 24-hours in advance to cancel an appointment.

History and Intake Form

Last Name: _____ First Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number (day): _____ Phone Number (night): _____

Email Address: _____ Occupation / Workplace: _____

Emergency Contact (name): _____ Emergency Contact (number): _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

Primary Care Provider: _____ ***Referring Physician:*** _____

Preferred Pharmacy

(Primary - *default*)

Name: _____

Phone Number: _____

City or Zip Code: _____

(Secondary – *if applicable*)

Name: _____

Phone Number: _____

City or Zip Code: _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ None
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign prostatic hyperplasia
- ☐ Cerebrovascular accident
- ☐ Chronic Anemia
- ☐ Chronic obstructive lung disease
- ☐ Coronary arteriosclerosis
- ☐ Deep Venous Thrombosis (Blood Clot)
- ☐ Depressive Disorders
- ☐ Diabetic on *Insulin*
- ☐ End Stage Renal Disease
- ☐ H/O: hypertension
- ☐ Human immunodeficiency virus infection
- ☐ Hypothyriodism
- ☐ Inflammatory disease of the liver
- ☐ Leukemia
- ☐ Malignant Lymphoma
- ☐ Malignant tumor of the breast
- ☐ Malignant tumor of the colon
- ☐ Malignant tumor of the lung
- ☐ Malignant tumor of the prostate
- ☐ Obstructive sleep apnea syndrome
- ☐ Primary fibromyalgia syndrome
- ☐ Pulmonary Embolism
- ☐ Rheumatoid Arthritis
- ☐ Type 2 diabetes mellitus
- ☐ Other

_____

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_____

History and Intake Form

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ None
- ☐ Bypass of stomach
- ☐ Heart: Coronary artery bypass graft
- ☐ Excision of basal carcinoma
- ☐ Excision of melanoma
- ☐ Excision of squamous cell carcinoma
- ☐ History of appendectomy
- ☐ History of cholecystectomy
- ☐ History of colectomy
- ☐ History of percutaneous transluminal coronary angioplasty
- ☐ History of tissue graft heart valve replacement
- ☐ Hysterectomy
- ☐ Lumpectomy of breast
- ☐ Mastectomy or left breast
- ☐ Mastectomy or right breast
- ☐ Mechanical heart valve replacement
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Tonsillectomy
- ☐ Uterus: Total Hysterectomy
- ☐ NONE
- ☐ Other

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_____

History and Intake Form

Orthopedic History

Have you had any of the following?

- ☐ Adhesive Capsulitis of shoulder
- ☐ Ankylosing Spondylitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ Complex regional pain syndrome
- ☐ History of osteoporosis
- ☐ Left-handed
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Primary gout
- ☐ Psoriasis with arthropathy
- ☐ Right-handed
- ☐ Sarcoma of bone
- ☐ Sarcoma of soft tissue
- ☐ Sciatica
- ☐ Secondary malignant neoplasm of bone
- ☐ NONE
- ☐ Other

_____
_____
_____
_____

Orthopedic Surgical History

Have you had any of the following?

- ☐ Arthroplasty of the carpometacarpal joint of the thumb
- ☐ Decompression of the lumbar spine
- ☐ History of arthroplasty of left knee
- ☐ History of arthroplasty right knee
- ☐ History of arthroscopy of knee joint
- ☐ History of repair of musculotendinous cuff of shoulder
- ☐ Lumbar spinal fusion
- ☐ Prosthetic arthroplasty of left hip
- ☐ Prosthetic arthroplasty of right hip
- ☐ Reconstruction of anterior cruciate ligament of the knee joint
- ☐ Release of trigger finger
- ☐ Repair of tendo achilles
- ☐ Total shoulder replacement
- ☐ Meniscus Repair
- ☐ Reverse Total Shoulder Replace
- ☐ NONE
- ☐ Other

_____
_____

History and Intake Form

Orthopedic Family History

Is there a history of any of the following? (*Immediate family

- ☐ Charcot Marie Tooth Disease
- ☐ Diabetes
- ☐ Hypertension
- ☐ Multiple Hereditary Exostosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Scoliosis

☐ NONE

☐ Other _____

Medications

Please list ALL current medications *(or check the box if it applies)*

☐ *Currently not taking any medication(s)*

Medication	Dosage	Frequency

History and Intake Form

Allergies

Please list ALL known allergies *(or check the box if it applies)*

☐ *No Known Allergies (NKA)*

Using the following options, describe your reaction(s) with severity provided below

Reaction Types			Severity Scale
Anaphylaxis	Angioedema	Diarrhea	Mild
Dizziness	Fatigue	GI upset	Mild to Moderate
Hives	Liver toxicity	Nausea	Moderate
Rash	Shortness of breath	Swelling	Moderate to Severe
Weal	Other: (specify)		Severe
			Fatal

Allergy	Reaction(s)	Severity
1.) _____	_____	_____
2.) _____	_____	_____
3.) _____	_____	_____
4.) _____	_____	_____
5.) _____	_____	_____

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Exercise Frequency (please choose one):

- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never

History and Intake Form

Review of Systems

Alerts

Please check yes for the following if it applies:

Symptom	Yes
Fever or Chills	
Rash	
Visual Changes	
Neck or Back Pain	
Nausea or Vomiting	
Constipation	
Painful Urination	
Frequent Urination	
Numbness or Tingling	
Anxiety	
Depression	
Weight loss	
Abnormal Bleeding	

Alert	Yes
Pacemaker	
Blood thinners	
Defibrillator	
Premedication prior to procedures	
Rheumatoid Arthritis	
RSD	
Allergy to shellfish/iodine	
Allergy to latex	
Allergy to adhesive	
Under pain management	