

Dear New Patient,

Welcome! Thank you for the opportunity to assist you with your orthopaedic problem. The following information will help you prepare for your visit with Dr. Jordan. We look forward to seeing you.

Please bring all past medical records and any study results related to your current problem to your first visit. If you have had X-rays, MRI, CT scan, or other imaging, we need both a report and a disc with the images. You can obtain these from the facility where you had them done, or have them forwarded to our office prior to your appointment.

**If you cannot make your appointment, please notify our office.**

**If you need language translation or interpreter assistance, please notify us in advance so we can make arrangements.**

Please complete the enclosed new patient paperwork prior to your first appointment. You may return it via email or fax (850) 916-8764, or present it at check in. Please bring your current insurance card and driver's license to your first appointment.

We appreciate the opportunity to provide you with orthopedic care as well as your cooperation in following the above guidelines. Should you have any questions, please do not hesitate to call our office at (850) 916-8760.

Sincerely,  
Kristina C. Beardsley, MSAT, ATC  
Practice/Surgery Coordinator

Patient Name: \_\_\_\_\_  
First MI Last Preferred Name Today's Date

\_\_\_\_\_ Sex: Male Female  
Social Security Number Date of Birth Email Address

\_\_\_\_\_ Zip  
Street Address City State

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work#: \_\_\_\_\_

**Marital Status:** Married Single Divorced Widowed **Race:** African American American-Indian Asian Caucasian Hispanic Other

**Guardian Information: (If Patient is a Minor):**

\_\_\_\_\_ Relationship to Patient Social Security Number  
First MI Last  
 \_\_\_\_\_ Sex: Male Female  
Date of Birth Contact Phone Number

**Injured/Painful Body Part:** \_\_\_\_\_ Affected Side: RIGHT LEFT BILATERAL  
 Date Problem Began or Injury Occurred: \_\_\_\_\_

**Please complete all that apply:**

Sport: \_\_\_\_\_ Position: \_\_\_\_\_ Level: \_\_\_\_\_  
 Team: \_\_\_\_\_ Coach's Name: \_\_\_\_\_ Trainers Name: \_\_\_\_\_  
 Student / School \_\_\_\_\_ Yr/Grade: \_\_\_\_\_ Occupation \_\_\_\_\_

Who Referred You? \_\_\_\_\_

If you would like us to forward our records to your referring doctor - please provide the address or fax number below:

\_\_\_\_\_  
 \_\_\_\_\_

**ONLY FILL OUT THIS SECTION IF YOU WERE IN JURED IN AN AUTO ACCIDENT:**

Did this injury occur as a result of a motor vehicle accident? Y N  
 Have you had emergency treatment for this injury? Y N Do you have a lawyer? Y N

**ONLY FILL OUT THIS SECTION IF THIS INJURY IS RELATED TO AN ON THE JOB ACCIDENT:**

(Professional athletes may skip this section)  
 Did this injury occur while you were working? Y N  
 Name of Employer: \_\_\_\_\_ Date Reported: \_\_\_\_\_  
 Your Position \_\_\_\_\_ Are you working? Y N Light Duty

**Payment Information:**

Form of Payment: (circle) Health Insurance    Auto Insurance    Worker's Compensation    Self Pay

**Primary Insurance**

Primary Insurance Company: \_\_\_\_\_ Insured's Name \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

**Secondary Insurance**

Secondary Insurance Company: \_\_\_\_\_ Insured's Name \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Agreement of Accuracy: The information provided in this history form is true and complete to the best of my knowledge.

Notice of Privacy Practices: I am aware that Andrews Orthopaedic and Sports Medicine Center has a "Notice of Privacy Practices" in accordance with Baptist Health Care's privacy policies. I understand that a copy is available to me and I agree with these privacy policies.

Release of Information: I authorize Andrews Orthopaedic and Sports Medicine Center to release medical information requested by my health insurance, Medicare, or third-party payers in order to assist in the payment of claims.

Self Pay Agreement: I agree to pay for medical services rendered at Andrews Orthopaedic and Sports Medicine Center. Should my insurance deny payment, I am responsible for the entirety of my bill. I understand that there are payment plans available at my request.

I authorize Baptist Physicians Group to disclose my health care information and to discuss my health care needs with those that I designate. I further authorize the release of my billing information to the following individuals and give them the ability to pick up prescriptions and/or forms, etc, on my behalf. A photo ID is required for any pick up. These individuals will be considered my emergency contacts. Without authorization, no information may be shared.

Important Note: If you may want or need any healthcare information or scheduling information released to any individuals they need to be specifically listed below. This includes individuals such as: a parent or child of a patient over 18 years of age, your primary care physician, your insurance policy holder, and/or sport coaches etc.

I authorize Baptist Physicians Group and his staff to disclose my personal health information to the following people:

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

I acknowledge that I have reviewed the above information.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

**Medical History:** Check if you have had any of these **medical problems** in the PAST:

MAJOR ILLNESS	YES	NO	MAJOR ILLNESS	YES	NO
Anemia			Diabetes		
Bleeding Problems			Insulin Dependent Diabetes		
Blood Clots			Gall Bladder Disease		
Stroke			Gastric Ulcers		
Auto-Immune Disorder			GI Disorders		
Rheumatoid Arthritis			Cancer: Type _____		
HIV/AIDS			Kidney Disease		
Hepatitis			Urinary Infections		
Liver Disease			Neuropathy		
Asthma			Numbness/Tingling		
Lung Disorders			Eye Disorders		
Chest pain/Angina			Psychiatric Illness		
Heart Problems			Steroid Use		
High Blood Pressure			Wound Healing Problems		
Thyroid Disease			OTHER:		

Please list any **operations/surgeries** you have had:

SURGERY/ REASON	YEAR	SURGERY/REASON	YEAR
1)		4)	
2)		5)	
3)		6)	

Please list any **Medications** that you are currently taking:

MEDICATION	DOSE	DOCTOR	MEDICATION	DOSE	DOCTOR
1)			5)		
2)			6)		
3)			7)		
4)			8)		

Do you have any **drug allergies?** Yes No

**LATEX Allergy?** Yes No

Please List:

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