Patient Name

TOM WINTERS, MD | ORTHOPAEDICS & SPORTS MEDICINE

Tel: (407) 649.1097 | **Fax:** (407) 841.3786 | **Email:** info@tomwintersmd.com | **Web**: www.TomWintersMD.com
1405 S. Orange Avenue, Suite 601, Orlando, FL 32806

Welcome to Tom Winters, MD. For over 30 years, Dr. Winters has been helping his patients overcome their injuries and rehabilitate... leaving them better than before! As our new patient, it's imperative that we find out as much as possible about you. This helps us streamline your visits and make your experience as "painless" as possible. As you may have assumed, paperwork is all part of the process, so please take a few moments to complete this packet for us. On behalf of our entire staff, we appreciate the trust that you have placed in us to care for you.

PATIENT INFORMATION

NAME (FIRST-MIDDLE-LAST)				AGE	SEX ☐ M ☐ F
STREET ADDRESS		CITY		STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	MARITAL STATUS ☐ S ☐ M ☐ W ☐ D	DATE OF BIRTH	SOCIAL SEC. NO.
EMPLOYER NAME & ADDRESS (IF MINOR, PARENT OR GUARDIAN)		CITY, STATE, ZIP		OCCUPATION / STUDENT	

RESPONSIBLE PARTY

NAME (FIRST-MIDDLE-LAST)		RELATIONSHIP	CONTACT PHONE NO.
STREET ADDRESS	CITY	STATE	ZIP
EMPLOYER NAME & ADDRESS (IF MINOR, PARENT OR GUARDIAN)	CITY, STATE, ZIP	PHONE	OCCUPATION

MEDICAL COMPLAINT

BODY PART WE ARE SEEING YOU FOR TODAY?		HOW LONG HAS IT BEEN HURTING?	
DATE SYMPTOMS STARTED?	WHERE DID YOUR INJURY / ACCIDENT OCCUR?	STILL WORKING? ☐ YES ☐ NO	DATE STOPPED WORKING?
HOW WERE YOU INJURED?		ATTORNEY NAME & PHONE NUMBER	
PRIOR TREATMENT?	WHEN?	WHERE?	
BY WHOM?	PRIOR X-RAYS? ☐ YES ☐ NO	WHEN?	WHERE?
HOW DID YOU HEAR ABOUT US?			
REFERRED BY	ADDRESS / PHONE		
PRIMARY CARE PHYSICIAN	ADDRESS / PHONE		

For Office Use Only

Name of Claim Adjuster: _____

Company: _____ Claim Number: _____

Phone: _____ Fax: _____

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PATIENT MEDICAL HISTORY

PATIENT NAME _____

HEIGHT:

WEIGHT:

HEALTH HISTORY OF PATIENT:

	YES	NO
ALLERGIES		
ANEMIA		
ASTHMA		
BLEEDING TENDENCIES		
BLOOD CLOTS		
CANCER		
DIABETES		
GOUT		
HEART TROUBLE		
HIGH BLOOD PRESSURE		
KIDNEY STONES		
LIVER TROUBLE		
LUNG DISEASE		
PHLEBITIS		
SEIZURES		
STOMACH ULCERS		
STROKE		
THYROID TROUBLE		
TUBERCULOSIS		

OTHER ILLNESSES AND/OR EXPLAIN ALL "YES" ANSWERS

FAMILY MEDICAL HISTORY

MOTHER:

FATHER:

CURRENT MEDICATIONS: (OR PROVIDE PREPARED LIST) DOSAGE:

ALLERGIES TO MEDICATION(S)? NONE ☐ IF YES, PLEASE SPECIFY BELOW:

PATIENT SOCIAL HISTORY

TOBACCO USE: ☐ NO ☐ YES - HOW MANY PACKS PER DAY? _____

ALCOHOL USE: ☐ NEVER ☐ OCCASIONAL ☐ MODERATE TO HEAVY

DRUG OVERUSE: ☐ NONE ☐ PRESENTLY ☐ PAST PROBLEM

SIGNATURE: _____ DATE: _____

Parent or Guardian if Minor

Patient Name

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PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as: Patient Name _____

- A basis for planning my care and treatment
- A means of communication among the health care professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment 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 quality and reviewing the competence of staff

I have been provided with a ***"Notice of Privacy Practices"*** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the "Notice" prior to acknowledging this authorization
- The right to restrict or revoke the use of disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care options.

I authorize the office of Thomas F. Winters, Jr., MD to download my medication history and Rx benefits into my account from an Rx clearinghouse.

Please tell us with whom we may discuss you/patient's treatment & appointment information (example: spouse, children, other relatives, friends, caregivers)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that as part of treatment, payment, or healthcare options, it may become necessary to disclose health information to another entity; i.e. referrals to other healthcare providers. I authorize such disclosure for these uses as permitted by law.

☐ Accept ☐ Decline

I fully understand and accept the information of this authorization.

Patient / Guardian Signature	Printed Name of Person Signing	Date

**If someone other than the patient is signing, are you the legal guardian, custodian, or have Power of Attorney for this patient, for treatment, payment, or healthcare options? ☐ Yes ☐ No

Patient Name

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STATEMENT OF FINANCIAL RESPONSIBILITY

- As a courtesy to our patients, we will bill your insurance company.
- You must present your current insurance card at the time of service.
- We must have your current insurance card on file in order to file claims on your behalf.
- All deductibles and co-pays are your responsibility and must be paid at the time of service.
- Self-pay patients must make payment when service is rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I accept responsibility for payment of all appropriate charges.

Patient / Guardian Signature

Patient Printed Name

Date