



Arthritis and Joint Center of Florida
109 Silver Palm Avenue
Melbourne, Florida 32901
321-956-1501 Ext. 203

Welcome to the Arthritis and Joint Center of Florida.
We are happy that you chose us for your orthopaedic needs.
Enclosed you will find your new patient paperwork.

*These forms are provided in electronic PDF format.
You have two options to choose from:*

1. You can use Adobe Acrobat Reader to fill out the forms
then Print them from your computer.

Please Note: (If you do not have the paid version of Adobe Acrobat you will NOT be able to save your changes.)

2. You can also print these and fill them out with an ink pen.

Please completely fill out the forms.
Bring these forms, your insurance card and a picture ID with you
to your scheduled appointment.

If your insurance requires a referral/authorization from
your Primary Care Physician (PCP), please contact your PCP
as soon as possible and have them fax a referral to our office
before your appointment. Fax # 321-956-1502

Please call our office the day before your appointment
to make sure we have received an authorization.

*****MEDICARE DOES NOT REQUIRE A REFERRAL.**

*****IMPORTANT: If you have previous x-rays,
YOU MUST BRING THE X-RAYS WITH YOU TO YOUR APPOINTMENT.**

Thank you for your cooperation.
The doctor and his staff look forward to seeing you.
If you have any questions or concerns, please feel free to contact us.

Daniel L. King, M.D.
Christopher Rhodes, P.A.

Patient Medical History

Name _____ Doctor _____

Please provide the following Medical History, problems etc. (If YES, explain)

Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
DVT/Blood Clots	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Hepatitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Gout	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Heart Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Lung Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Urinary/Kidney	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Stomach Ulcers	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
T.B.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Thyroid	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Tobacco Use	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How Much? _____
Alcohol/Drug Use	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How Much? _____
Pregnant	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Nursing? Yes <input type="checkbox"/> No <input type="checkbox"/>
Other (Explain)	_____		
Are you claustrophobic?	_____	Do you have a pacemaker?	_____

Current Medications, Dose, Frequency, Reason For Taking Medication:

1.	5.
2.	6.
3.	7.
4.	8.

Previous Surgeries:

1.	3.
2.	4.

Allergies to Medications (Describe Reactions):

1.	3.
2.	4.

Are You Allergic to Shell Fish? _____ Food Allergies? _____

Describe Your Present Problem:

*AGE _____ *HEIGHT _____ **WEIGHT _____

Family Physician: _____ Date: _____

Patient Signature: _____ Nurse: _____

SURGERY DATE _____ REFERRAL DATE _____ 1) _____
FUD _____ EXP. DATE _____
DX: _____

THIS SECTION IS FOR OFFICE USE ONLY (Write in pencil.) 2) _____

PATIENT INFORMATION

Date of first visit _____

PLEASE PRINT CLEARLY

Doctor you are seeing today _____

PATIENTS NAME _____

SEX _____ MARITAL STATUS _____ DATE OF BIRTH _____ AGE _____

ADDRESS _____
(Street / Apt.) (City) (State) (Zip)

MAILING ADDRESS (if different from above) _____

TELEPHONE _____ SOCIAL SECURITY NUMBER _____

EMPLOYED BY _____ TELEPHONE _____

OCCUPATION _____

EMPLOYER'S ADDRESS _____
(Street / Apt.) (City) (State) (Zip)

SPOUSE'S NAME _____ SOCIAL SECURITY NUMBER _____

EMPLOYED BY _____ ADDRESS _____

COMPLETE THIS SECTION IF PATIENT IS A MINOR (under 18)

NAME OF PERSON RESPONSIBLE FOR CHARGES _____
(Print) (Signature)

RELATIONSHIP TO PATIENT _____ SOCIAL SECURITY NUMBER _____

ADDRESS _____ PHONE NUMBER _____ EMPLOYER _____

CHIEF COMPLAINTS _____

IS VISIT RELATED TO INJURY AT WORK _____ IF SO, DATE OF INJURY _____

WERE YOU IN AN AUTOMOBILE ACCIDENT _____ IF SO, GIVE DATE OF ACCIDENT _____

IF SPOUSE OR PARENT ARE UNAVAILABLE

NAME AND RELATIONSHIP OF PERSON TO CONTACT IN AN EMERGENCY _____

PHONE# _____ RELATIONSHIP _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

NAME AND SIGNATURE OF RESPONSIBLE PARTY _____

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HEALTH INFORMATION RELEASE

In order to assist you in receiving your health information from the Arthritis and Joint Center of Florida, please complete this section. I authorize the persons listed below to have access to any and all my health information, including HIV, drug and alcohol abuse and psychiatric records. Arthritis and Joint Center of Florida, is permitted to share my medical information with them, including test results and information disclosed during office visits. Persons authorized to receive my medical information (full name and phone number):

NAME

PHONE

_____	_____
_____	_____
_____	_____

You may notify me or the parties listed above with normal test results, appointment reminders and other information regarding my health information as follows:

_____ Message on answering machine	Phone Number _____
_____ Message on work voicemail	Phone Number _____
_____ Message on pager	Phone Number _____
_____ Message on cell phone	Phone Number _____
_____ Other	_____

I understand and direct that this authorization will remain in effect until it is revoked by me in writing. And, I have received a copy of the HIPAA Notice of Privacy Practices for the Arthritis and Joint Center of Florida.

Patient (Print Name)

Witness (Print Name)

Patient Signature

Witness Signature

Date

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to Arthritis & Joint Center of Florida of the physician's benefits otherwise payable to me, but not to exceed the physician's regular charges for this period of treatment. I understand I am financially responsible to Arthritis & Joint Center of Florida for charges/benefits not covered by this assignment. I also understand the Arthritis & Joint Center of Florida is not responsible for the terms of the Contract(s) which I have with my Insurance Company(ies) and that in certain circumstances my Company(ies) may determine to pay all, some, or none of the charges resulting from my medical care.

SIGNATURE _____ DATE _____
(Policy Holder)

AUTHORIZATION

I hereby authorize The Arthritis & Joint Center of Florida or any of their physicians who have attended me to furnish my Insurance Company(ies) or representatives with any and all information that may be contained in their medical records.

SIGNATURE _____ DATE _____

THIS SECTION FOR OFFICE USE ONLY

INITIALS _____ INITIALS _____ INITIALS _____

DATE _____ DATE _____ DATE _____

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