COAST
ORTHOPEDIC CENTER
James D. Glenn, M.D., FAAOS

1781 Garden St.
Titusville, Fl 32796

Suite D • Titusville, Florida 32796 • Telephone (321) 269-4300 • Fax (321) 269-7755

OFFICE POLICY AND GENERAL INFORMATION

INSURANCE

Please have your insurance card and your photo ID with you at your appointment. If you show up without proof of insurance, you will be fully responsible for all charges and will be charged for the visit. There will be NO exceptions. If you insurance changes, it's your responsibility to bring in your new insurance card at your appointment so we can update our records and verify your coverage.

CANCELLATION POLICY

Our patient's time is very important to us, if you need to cancel or change your appointment, please call us with 24 hours and do so. We will make every effort to get you rescheduled as soon as possible. By not calling in advance you will incur a cancellation fee to your account of $25.00. If you do not show up for your appointment your account will incur a no show fee of $25.00.

PRESCRIPTIONS

In order to efficiently refill your prescriptions that were written by Dr Glenn, have your pharmacy fax a request to our office at 321-269-7755. Allow a minimum of 3-4 business days for our office to process your request and your prescriptions to be filled.

HIPPA

Our office is compliant with all mandated HIPPA privacy requirements. Please make sure when you fill out the privacy form that includes all persons you would want your medical information released to. If the name does not appear on your privacy form we will not divulge any of your information.

MEDICAL RECORDS

A medical release form must be signed by you in order to release your records to another facility. Allow up to 10 business days once the request form has been signed. There is no charge for the first copy of your medical records however there is a charge of .50 a page after the first copy. There is a $5.00 charge for each digital x-ray disc. Allow 3-4 days for the disc to be available for pickup.

CO-PAYMENTS

All co-payments will be collected at the time of arrival prior to being treated. Please have co-payment ready and give to the receptionist when signing in. All services rendered without coverage of insurance will be collected at check out.

_____

Signature date

Effective 6/6/15

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PATIENT INFORMATION

Patient Name _____ Race _____ Age _____ Sex _____

Social Security _____ Drivers License # _____

Birth date _____ Single _____ Married _____ Divorced _____ Separated _____

Physical Address _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employed By _____ City _____ State _____ Zip _____

Spouse's Name _____ SS# _____ Birth Date _____

Employed By _____ City _____ State _____ Zip _____

Work Phone _____ Occupation _____

If Child, Parent's Name _____

Referred by _____ Family Physician _____

Medical Insurance Yes _____ No _____ Ins Co. _____

ID# _____ Group # _____ Code _____

PERSON TO CONTACT IN EMERGENCY _____ Phone: _____

ASSIGNMENT OF BENEFITS

A photocopy of this signature is to be considered as valid as an original. I understand that I am responsible for all charges whether or not paid by my insurance. I hereby authorize my insurance company to release all information necessary to complete my claim.

Signed _____ Date _____

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PATIENT HISTORY FORM

NAME: _____ AGE: _____ OCCUPATION: _____ PHARMACY: _____

CIRCLE ONE OR MORE

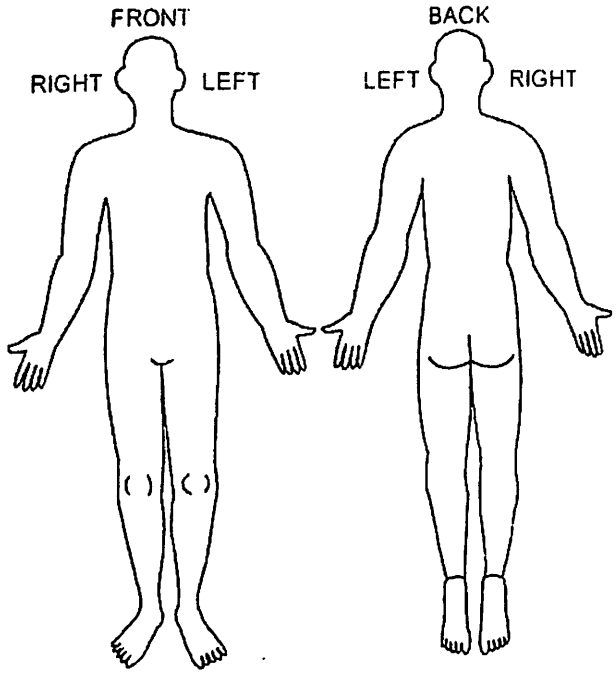
1. How did the injury occur or pain start?
   a. Suddenly
   b. Gradually
   c. Slip and Fall
   d. Lifting
   e. Injured at work
   f. Auto accident
   g. Sports
   h. No apparent cause
2. When did the injury occur or pain start?
   Date:
3. Did you experience any other injury at this time?
   Yes No if yes, what other injury occurred?
4. Frequency of pain:
   a. Initially but not now
   b. Occasionally
   c. All the time

   How bad is the pain?
   a. Mild
   b. Moderate
   c. Marked
   d. Severe
5. What activities make the pain worse?
   a. Exercise/movement
   b. Rest/night
   c. Throwing
   d. Running
   e. Walking
   f. Standing
   g. Bending
   h. Twisting
   i. Sneezing
   j. Lifting
   k. Sitting
   l. After a day's work
6. What makes your pain better?
   a. Rest
   b. Pain pills
   c. Physical Therapy
   d. Aspirin
   e. Nothing
   f. Other
7. Does your pain keep you from:
   a. Working
   b. Having fun
   c. Sports
   d. Exercises
   e. No limitations
   f. Other
8. Do you have or have you had:
   a. Buckling
   b. Joint grinding
   c. Joint catching
   d. Locking
   e. Joint slipping out
   f. Swelling
9. Do you have to stop some/all activities because of your pain? Yes No If yes How long?
10. Have you been treated prior to the accident/injury for this same kind of problem? Yes No
11. What treatment have you had?
    a. Surgery
    b. Medication
    c. Physical Therapy
    d. Hospitalization
12. Have you had any studies done for this problem?
    a. MRI? Yes No
    b. Arthrogram? Yes No
    c. Bone scan? Yes No
    d. EMG? Yes No
    e. Myelogram? Yes No
    f. CT scan? Yes No
    g. X-rays? Yes No

SHOW THE DOCTOR WHERE IT HURTS

Please mark the areas on the diagram below where you feel the described sensations on your body. Use the appropriate symbol and include all affected areas.

NUMBNESS ----
BURNING xxx
PINS & NEEDLES oooo
STABBING ////



WORKER'S COMPENSATION/ AUTO ACCIDENTS

1. Present Employer: _____
2. Date of Injury: _____ Date Last Worked: _____
3. Current Work Status: _____
4. Type of work duties: _____
5. How long have you worked in this capacity? _____
6. How did the injury occur? _____
7. If auto accident, were seatbelts on? Yes No
8. Are you Right Left Handed
9. Have you had any previous work/auto related injuries?
   Yes No If yes please list (include dates & body parts)

PLEASE LIST THE THREE (3) MOST IMPORTANT QUESTIONS YOU WOULD LIKE THE DOCTOR TO ANSWER

_____

_____

_____

MEDICAL HISTORY

Are you presently under the care of a physician? Yes No
If so, name and address

State your general health in your own words:

PAST HISTORY

List medications you are presently taking:

Do you have any drug allergies? Yes No
If so, list them & reaction:

Have you had a bone density test?
Yes No
Date of Last Test:_____

Previous surgery? Yes No
If so, list:

Hospital Admissions? Yes No
If so, list:

Have you ever had or do you now have:

Yes	No	Diabetes
Yes	No	Heart disease
Yes	No	High blood pressure
Yes	No	Cancer
Yes	No	Arthritis
Yes	No	Asthma
Yes	No	Epilepsy
Yes	No	Fracture/dislocations
Yes	No	Anesthesia reaction

FOR WOMEN ONLY
Are you pregnant? Yes No
If yes, due date:

FAMILY HISTORY

Do any of your parents, brothers, sisters or children Have any of the following:

Yes	No	Diabetes
Yes	No	Heart Disease
Yes	No	High blood pressure
Yes	No	Cancer
Yes	No	Kidney disease
Yes	No	Stroke

Mother year of birth:_____ year of death_____
Father year of birth:_____ year of death_____

SOCIAL HISTORY

Yes	No	Do you smoke? ____packs a day, former____
Yes	No	Do you drink alcohol?
Yes	No	Used heroin, cocaine, speed, marijuana or similar substances?
Yes	No	Has your partner ever harmed or threatened to harm you or someone you love?
Yes	No	Have you ever been physically hurt in an intimate relationship?
Yes	No	Are you on temporary or permanent disability?

REVIEW OF SYSTEMS

Have you ever had or do you now have:

Constitutional

Yes	No	Unexplained fever
Yes	No	Unexplained weight loss or gain

Eyes, Ears, Nose & Throat

Yes	No	Problems with eyes, ears and/or nose
Yes	No	Difficulty swallowing, sore throat

Cardiovascular

Yes	No	Chest pain
Yes	No	Palpitations of the heart
Yes	No	Shortness of breath
Yes	No	Swelling of the ankles or feet

Genitourinary

Yes	No	Blood in the urine
Yes	No	Kidney or bladder problems
Yes	No	Sugar or protein in the urine

Respiratory

Yes	No	Chronic cough
Yes	No	Coughed up Blood

Skin

Yes	No	Skin rashes

Musculoskeletal

Yes	No	Swollen or painful joints
Yes	No	Deformity in joints

Neurological

Yes	No	Frequent or severe headaches
Yes	No	Dizziness or fainting spells

Gastrointestinal

Yes	No	Heartburn
Yes	No	Stomach ulcers
Yes	No	Blood in the stool
Yes	No	Tarry stools

Hematologic

Yes	No	Excessive bleeding
Yes	No	Blood clots or phlebitis
Yes	No	Swollen glands

Psychiatric

Yes	No	Depression or excessive worry
Yes	No	Nervous troubles

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

FOR COAST ORTHOPEDIC CENTER

SECTION A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below for purposes other than payment, treatment and health care operations. I understand that the information I authorize a person or entity to receive maybe re-disclosed and no longer protected by federal privacy regulations.

Patient Name: _____ **Date:** _____

I give my permission to discuss my medical care with the following people:

1) _____
2) _____
3) _____
4) _____
5) _____

****Please Note**: If one of your loved ones calls our office and their name does not appear above, we WILL NOT be permitted to share any information pertaining to your treatment and/or condition. However, it is the preference of Dr. Glenn to speak directly to the patient.**

This authorization is valid for one year. I understand that it is my responsibility to notify this office if there is any change.

SECTION B: Only applies if the Practice is requesting the information for its own uses and disclosures

The information will be used/disclosed for the following purposes:

_____

_____

I understand that this Authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign or my revocation of this Authorization will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

The person/organization authorized to use/disclose the information will receive compensation for doing so. Yes__ No___

SECTION C: My Rights

I understand that inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I understand that I may revoke this Authorization at any time by notifying Coast Orthopedic Center, PA in writing. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

I have the right to receive a copy of this Authorization.

This authorization expires on the following date ____/____/_____ (dd/mm/yyyy)

SECTION D: Signature

Date:_____ Time:_____am/pm

_____ _____

Signature of patient or patient's representative Relationship to patient