DAVID D. DORE M.D.
Director of Joint Replacement Surgery at Celebration Health

FAISSAL ZAHRAWI, MD, F.A.C.S.
Director of The Spine Center at Celebration Health

BRAD HOMAN, D.O.
Director of Sports Medicine at Celebration Health

CELEBRATION ORTHOPAEDIC & SPORTS MEDICINE INSTITUTE & SPINE CENTER

410 Celebration Place, Suite 106 • Celebration, FL 34747
(407) 764-4270 (Osceola County) • Fax (407) 764-4271
(407) 303-4270 (other areas) • Fax (407) 303-4271

DUANE McRORIE, D.P.M.
Foot/Ankle Surgery

DAVID A. CRUMBIE, M.D.
Sports Medicine/ Orthopaedic Surgery

MATTHEW JOHNSTON, D.O.
Joint Replacement/General Orthopaedics

PATIENT INFORMATION

Who is responsible for Patient? ☐ Self ☐ Parent ☐ Employer ☐ Other _____

How did you hear about us?_____

Patient's Last Name_____ First Name_____ Middle Initial_____

Patient's Social Security Number_____

Address_____Apt #_____

City_____ State_____ Zip Code_____

Telephone #: Home ( ) _____ Business: ( ) _____

Date of Birth_____ Sex: ☐ Male ☐ Female

Do you have an alternate address? ☐ Yes ☐ No If yes, please print here_____

_____

Marital Status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employment Status (check one): ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Other_____

Employer:_____ Occupation:_____

Employer Address_____

Student? ☐ Yes ☐ No ☐ Full-Time ☐ Part-Time

_____

Spouse/Parent Name: Last_____ First_____ Middle Initial_____

SSN: _____ Date of Birth:_____

Employer:_____

Employer Address:_____ Phone #:_____

Spouse/Parent Name: Last_____ First_____ Middle Initial_____

SSN: _____ Date of Birth:_____

Employer:_____

Employer Address:_____ Phone #:_____

_____

Name of closest relative not living with you: _____

Relationship:_____ Phone #: _____

_____

Referring Physician:_____

Address:_____ Phone #:_____

PLEASE FILL OUT REVERSE SIDE

INSURANCE INFORMATION

PLEASE PRINT

Primary Insurance Co: _____ Secondary Insurance:_____

Insured's Name_____ Insured's Name_____

Relationship to Patient:_____ Relationship to Patient:_____

ACCIDENT INFORMATION

EMPLOYER: _____ Date of Injury:_____

Place of Accident or Injury:_____ Was the Accident: ☐ Work-Related ☐ Auto-Related

Date & Time of Accident:_____ ☐ Other _____

Do you have notice of injury on file? ☐ Yes ☐ No W.C. Claim #:_____

Attorney Name:_____ Insurance Co:_____

Policy Holder:_____ Address:_____

I.D. #:_____ _____ Zip:_____

Telephone #:_____ Were X-rays taken of this injury or problem? ☐ Yes ☐ No

If yes, where were X-rays taken?_____ Date X-rays taken:_____

PLEASE HAVE YOUR INSURANCE CARD AND DRIVER'S LICENSE READY FOR THE RECEPTIONIST.

PAYMENT FOR PROFESSIONAL SERVICES IS DUE AND PAYABLE WHEN SERVICE IS RENDERED.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(to be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed:_____ Date:_____

Relationship (f not signed by patient):_____

I wish to place the following restrictions on disclosure of my health information:

_____

Internal Use Only - If patient/patient's representative refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below.

Presented on (date and time):_____ By (name and title):_____

RELEASE OF MEDICAL RECORDS

I hereby authorize the release of medical, psychiatric, alcohol and HIV testing and/or drug abuse information for insurance carriers or for continuing patient care. I further agree to have my physician maintain my health information data for the purpose of education, research and publication in professional journals and medical books. However, any publication of these will exclude my name so as to protect my identity.

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF PARENT, GUARDIAN AND/OR RESPONSIBLE PARTY DATE

_____

CONSENT FOR EVALUATION OR TREATMENT

Undersigned hereby consents to whatever evaluation or treatment the assigned physician deems necessary to the above named patient.

_____ _____

SIGNATURE OF PARENT, GUARDIAN AND/OR RESPONSIBLE PARTY DATE

INSURANCE ASSIGNMENT & RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to **Celebration Orthopaedics and Sports Medicine Institute** all insurance benefits, if any, otherwise payable to me for services 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.

The above-named physician may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Patient Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Patient Guardian or Patient Representative Relationship to patient

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MEDICARE/MEDIGAP AUTHORIZATION

Patient Name:_____ Date of Birth:_____

Medicare #: _____ Patient I.D.#:_____

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to **Celebration Orthopaedic & Sports Medicine Institute**, for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, any Medigap insurer, and their agents any information needed to determine these benefits and related services.

_____ _____

Signature of Patient, Patient Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Patient Guardian or Patient Representative Relationship to patient

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FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____ _____

Signature of Patient, Patient Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Patient Guardian or Patient Representative Relationship to patient