

**ESTABLISHED PATIENT INFORMATION UPDATE FORM  
SUNCOAST ORTHOPAEDIC SURGERY & SPORTS MEDICINE**

**Please Complete and return at time of appointment**

**PLEASE PRINT**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone# \_\_\_\_\_

Are you a resident of a Skilled Nursing Facility? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, where? \_\_\_\_\_

Have you had any changes to your insurance since your last visit? \_\_\_\_\_ Yes. \_\_\_\_\_ No. If yes, please provide new insurance cards at check-in.

**Medical Information:**

Why are you seeing the doctor today? \_\_\_\_\_  
(Chief Complaint)

Have you seen us for this problem in the past? \_\_\_\_\_ Yes \_\_\_\_\_ No.

If yes, date last seen at Suncoast Orthopaedics for this problem (estimate): \_\_\_\_\_

Since your last visit, have you experienced any change in:

1. Medications \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list current medications or provide a copy of your current medication list at check-in:

2. Your Health: \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, indicate the changes below:

a) New Surgeries: \_\_\_\_\_

b) New Hospitalizations (Indicate where, when and why) \_\_\_\_\_

c) New Illnesses/Accidents: \_\_\_\_\_

d) New Tests/Exams: \_\_\_\_\_

e) Other changes: \_\_\_\_\_

f) Are you allergic to any medications? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please list: \_\_\_\_\_

**Review of Systems:**

**CONSTITUTIONAL:**

	Past	Present
Fever	_____	_____
Chills	_____	_____
Glaucoma	_____	_____
Cancer	_____	_____
Night Sweats	_____	_____

**CENTRAL NERVOUS SYSTEM:**

	Past	Present
Stroke	_____	_____
Seizures	_____	_____
Blackouts	_____	_____
Dizziness	_____	_____
Headaches	_____	_____
Visual Problems	_____	_____
Hearing Problems	_____	_____

**MUSCULOSKELETAL:**

	Past	Present
Rheumatoid Arthritis	_____	_____
Osteoporosis	_____	_____
Fibromyalgia	_____	_____
Birth Defects	_____	_____

**INTEGUMENTARY:**

	Past	Present
Rashes	_____	_____
Burns	_____	_____

**CARDIAC:**

	Past	Present
Palpitations/	_____	_____
Irregular Heartbeat	_____	_____
Chest Pain	_____	_____
Heart Attack	_____	_____
Heart Failure	_____	_____
High Blood Pressure	_____	_____
High Cholesterol	_____	_____
Peripheral Vas Disease	_____	_____

**RESPIRATORY:**

	Past	Present
Cough	_____	_____
Shortness of Breath	_____	_____
Asthma	_____	_____
Tuberculosis	_____	_____
Sinus Infection	_____	_____
Pneumonia	_____	_____
<b><u>URINARY:</u></b>		
Difficulty Urinating	_____	_____
Difficulty Urinating	_____	_____
Kidney Problem	_____	_____
Prostate enlargement	_____	_____

**ENDOCRINE:**

	Past	Present
Diabetes	_____	_____
Hyperthyroidism	_____	_____
Hypothyroidism	_____	_____

**HEMATOLOGIC:**

	Past	Present
Anemia	_____	_____
Bleeding disorder	_____	_____
Sickle Cell Disease	_____	_____
Blood Clot/DVT	_____	_____
Phlebitis	_____	_____
Bruising	_____	_____

**GASTROINTESTINAL:**

	Past	Present
Nausea	_____	_____
Vomiting	_____	_____
Liver Disorder	_____	_____
Ulcers	_____	_____
GERD	_____	_____
Internal Bleeding	_____	_____
Diarrhea	_____	_____

I have none of the conditions/symptoms listed above \_\_\_\_\_

Initials

Do you have HIV/AIDS? \_\_\_\_\_ Yes \_\_\_\_\_ No MRSA? \_\_\_\_\_ Yes \_\_\_\_\_ No

Hepatitis? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, \_\_\_\_\_ Type A \_\_\_\_\_ Type B \_\_\_\_\_ Type C

**I CERTIFY TO THE BEST OF MY KNOWLEDGE THAT THE INFORMATION THAT I HAVE PROVIDED IS ACCURATE:**

**PATIENT signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Information reviewed by:**

**PHYSICIAN Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**AUTHORIZATION**

**AUTHORIZATION/CONSENT FOR EXAMINATION AND TREATMENT:**

I hereby acknowledge that I have voluntarily presented myself, or my child (if patient is a minor) for medical treatment at Suncoast Orthopaedic Surgery & Sports Medicine.

**RELEASE OF MEDICAL INFORMATION:**

I authorize the Doctors of Suncoast Orthopaedic Surgery & Sports Medicine to release any information concerning my care to my insurance company. I also authorize the release of information to any agency necessary for payment on my account. I authorize Suncoast Orthopaedic Surgery & Sports Medicine to release records to any doctor and/or medical facility that they deem pertinent to my care.

**ASSIGNMENT OF BENEFITS:**

I request that the payment of authorized Medicare and/or Insurance benefits be made on my behalf. I assign benefits to the physician or organization furnishing services.

Are you the primary holder on your insurance? \_\_\_\_\_ Yes. \_\_\_\_\_ No.

If No, please complete the following **Guarantor Information:**

**Guarantor Name:** \_\_\_\_\_

**Guarantor Address:** \_\_\_\_\_ **Tel #** \_\_\_\_\_ (if different from yours)

**Guarantor Date of Birth:** \_\_\_\_\_ **Social Security Number** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_

Please be prepared to provide a copy of your insurance cards and photo ID at check-in, if requested.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE AUTHORIZATIONS. I CERTIFY TO THE BEST OF MY KNOWLEDGE THAT THE INFORMATION THAT I HAVE PROVIDED IS ACCURATE:

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

