ORTHOPAEDIC ASSOCIATES
The Strength of Experience

Fort Walton Beach
1034 Mar Walt Drive
Fort Walton Beach, FL 32547

Destin
36474C Emerald Coast Parkway, Suite 3101
Destin, FL 32541

Niceville
554-D Twin Cities Boulevard
Niceville, FL 32578

Crestview
5300 South Ferdon Boulevard
Crestview, FL 32536

PATIENT INFORMATION: **E-MAIL:**_____

LAST NAME:_____ **FIRST:**_____ **M:**_____

LOCAL ADDRESS:_____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

MAILING ADDRESS:_____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

SOCIAL SECURITY NO:_____ **DATE OF BIRTH:**_____ **AGE:**_____

HOME PHONE:_____ **CELL PHONE:**_____ **SEX:** □ **M** □ **F** **MARITAL STATUS:** □ **S** □ **M** □ **D** □ **W**

EMERGENCY CONTACT PERSON:_____ **RELATION:**_____

EMERGENCY NUMBER:_____

EMPLOYMENT INFORMATION: PATIENT OR PARENT

EMPLOYER:_____ **OCCUPATION:**_____ **EMPLOYEE NAME:**_____

ADDRESS:_____ **CITY:**_____ **STATE:**_____

ZIP CODE:_____ **WORK PHONE:**_____ **EXT:**_____

RESPONSIBLE PARTY (If different from above or if patient is a minor):

NAME:_____ **SOCIAL SECURITY:**_____

MAILING ADDRESS:_____

PHONE:_____ **DATE OF BIRTH:**_____ **MARITAL STATUS:**_____

RELATION TO PATIENT: □ **SPOUSE** □ **PARENT** □ **STEP-PARENT** □ **OTHER**

HOW DID YOU HEAR ABOUT US: _____

PRIMARY CARE PHYSICIAN: _____ **REFERRING PHYSICIAN:**_____

PREFERRED PHARMACY: _____

PRIMARY INSURANCE: (Please provide copy of insurance card)

Name of Insurance _____ **Policy#** _____ **Group#** _____

Address of Insurance Company_____

Name of Policy Holder _____ **Relationship to Patient** _____

SECONDARY INSURANCE: (If applicable)

Name of Insurance _____ **Policy#** _____ **Group#** _____

Address of Insurance Company_____

Name of Policy Holder _____ **Relationship to Patient** _____

PATIENT SIGNATURE: _____ **DATE:** _____

Orthopaedic Associates, P.A., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability,

ARBITRATION AGREEMENT BETWEEN DOCTOR AND PATIENT
(Please read carefully)

This agreement is made between Orthopaedic Associates and Theodore I. Macey, M.D., Mark J. Tenholder, M.D., Jason W. Thackeray, M.D., Michael Shawbitz, M.D., James F. Watt, D.O., Donald Chipman, M.D., Dale Landry, M.D., Thomas Fusco, D.P.M., Jacob Seales, M.D., Brandon Cook, M.D., Jack E. McKay, M.D. David J. Dean, M.D., Robert J. White, D.P.M. and their physician extenders, agents, employees, or any of the foregoing referred to hereinafter as "doctors" and _____ hereinafter referred to as "patient".
(Patient name)

It is the intention of the parties to this agreement to bind not only themselves, but also their heirs, personal representatives, guardians, or any other persons deriving their claims through, and on behalf of, the patient.

It is understood by the patient that he or she has voluntarily selected, and he or she is neither required to use Orthopaedic Associates nor any of the doctors involved in their treatment and that there are other competent Orthopaedic physicians in Florida who may act as the patient's treating physician.

It is further understood that in the event of any controversy or dispute which might arise between the doctor and the patient, regardless of whether the dispute concerns the medical care rendered, or payment of surgical or other fees, or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682, Florida Statues.

Disputes and Consideration; In the unfortunate event of any claim for medical malpractice or otherwise, and in consideration for this agreement, the parties would like to (a) keep things as simple as possible; (b) enhance early resolution of their differences; (c) avoid lengthy drawn-out litigation through the courts; (d) avoid the stress associated with traditional litigation and jury trials; and (e) minimize all costs, expenses, and attorney's fees.

This arbitration shall be binding and shall be in lieu of, and instead of, any trial by judge or jury. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. Each party shall be entitled to the discovery available for under the Florida Rules of Civil Procedure. The panel of three (3) arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and may be enforced by a court of competent jurisdiction.

Duty to Defend and Indemnify: For each individual or entity with a claim that is not bound by this agreement ("non-party"), it is the parties' intent that they shall adopt and comply with this agreement 100% so that the parties can avoid piecemeal litigation and ensure consistency, closure, and finality in one forum. For each non-party claim against the patient's physician brought outside this agreement, you shall (a) defend and (b) indemnify the patient's physician against said claim(s).

If any provision of this Agreement shall be held invalid under any applicable laws, such invalidity shall not affect any other provision of this Agreement that can be given effect without the invalid provision. Further, all terms and conditions of this Agreement shall be deemed enforceable to the fullest extent permissible under applicable law, and, when necessary, the court is requested to reform any and all terms or conditions to give them such effect.

Patient initials _____ I understand that by signing this agreement I am waving my right to a jury trial, and instead, have agreed to participate in arbitration.

This agreement shall remain in effect for all treatment and surgery provided to the patient, presently and at any future date.
By signing below, I am indicating that I have read and agree to the foregoing terms.

In witness whereof, we have set our hands this date: _____

PATIENT:

By: _____
(Patient Signature as Authorized as Agent)

_____
Patient's Spouse, if available

WITNESS:

By:_____
(Employee of Orthopaedic Associates)

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MEDICATION RECORD

Today's Date: _____

Patient Name (Last): _____

Patient Name (First): _____ Middle Initial: _____

Height: _____ Weight: _____ Date of Birth: _____

Patient's Family Doctor: _____

Preferred Pharmacy: _____ Location: _____

Medication (including over the counter & supplements)	Frequency

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Authorization for Release of Medical Information

I, _____, give Orthopaedic Associates permission to release and/or discuss my medical records or conditions with the following individual(s):

Name:	Relationship to the patient:
_____	_____
_____	_____
_____	_____
_____	_____

_____
Patient signature

_____
Date

_____
Witness signature