Florida Joint Care Institute
2165 Little Road, Trinity, FL 34655
Phone (727) 372-6637 Fax (727)375-5044
Dr. Jennifer Cook, Dr. Stephen Hanff, Dr. James Donovan, Dr. Aaron Mates

Thank you for choosing Florida Joint Care Institute for your orthopedic needs. We have prepared this packet of information and forms in order to make your first visit with us a convenient and pleasant experience. We ask that you complete the attached paperwork prior to your arrival.

When you come for your appointment please bring the following:

- ✓ Completed New Patient paperwork
- ✓ Medical Insurance Card(s)
- ✓ A complete list of ALL medications including strengths and dosage
- ✓ Photo ID driver's license or state issued ID
- ✓ X-Ray and MRI's. If you have had any imaging pertaining to the body part our office will be treating, please be sure to bring them with you.

Please be prepared to pay for the following at the time of your visit:

- ✓ Co-payment. If your insurance requires a co-payment, you are responsible for this at the time of your appointment.
- ✓ Co-insurance and Deductible. If your insurance requires a co-insurance or deductible, you are responsible for this at the time of your appointment.
- ✓ If you do not have insurance, payment is expected at the time of service.

Referrals/Authorizations: We will attempt to get your referral/authorization from your primary care physician (if one is needed); however, it is always a good idea for you to call them ahead of time to let them know of your appointment.

Please Check-In 15 minutes prior to your scheduled appointment time to allow our staff to complete the administrative portion of your appointment.

Thank you!

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Patient Name_____ _____ _____
LAST MI FIRST

Date of Birth_____/_____/_____ **SSN** _____

E-Mail Adress_____

Mailing Address_____

City_____ **State**_____ **Zip Code**_____

Primary Phone Number_____

Secondary Phone Number_____

Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced ( ) Separated

Primary Care Physican_____ **Phone** _____

Insurance: Primary _____ **ID#**_____

Policy Holder Name _____ **DOB**_____/_____/_____

Secondary_____ ID#_____

Policy Holder Name_____ DOB_____/_____/_____

Pharmacy Information: Name_____ **Phone**_____

Pharmacy Address_____

Designated Relative

I authorize discussion and release of my general medical condition and diagnosis (including treatment, payment and health care option) with my:
Please list the member(s) or significant other, if any, whom we may inform about your medical condition, and/or in case of an emergency:

Name_____ Relation _____ Phone_____

Name_____ Relation _____ Phone_____
( ) I don't authorize any person(s) to obtain or discuss any of my medical conditions or diagnosis.

Messages may be left on my answering machine or voicemail box regarding my health and upcoming appointment dates and time: ( ) yes ( ) no