

Date: _____

Dr: _____

Chart #: _____



WELCOME

Thank you for selecting our healthcare team! To help us meet your healthcare needs, please fill out this form completely.

How did you hear about us? Friend/Family Yellow Pages TV/Advertisement
 Referred by Dr. _____ from City _____ State _____
Your Primary Care Physician is: _____ City/State: _____

Patient's Name: First _____ MI _____ Last _____
Patient's Address: _____ City _____ State _____ Zip _____
DOB: _____ SS# _____ Married Single Male Female
Home # () _____ Mobile # () _____ Work # () _____
Employer Name: _____ City: _____
Best time to reach you? Time: _____ Day of Week: _____

In the event of an emergency please contact:

Name: _____ Relationship to Patient: _____
Work Phone _____ Home Phone _____ Mobile _____

Place of Injury	<input type="checkbox"/> Work	<input type="checkbox"/> Auto	<input type="checkbox"/> Other _____
Current Problem (area of body) _____			
Left side: _____	Right side: _____	State injury occurred in: _____	
Is this visit related to an accident or a specific event? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, date of injury _____			

Responsible Party IF DIFFERENT FROM PATIENT

Name: _____ Relationship to Patient: _____
DOB: _____ SS# _____ Male Female
Work Phone _____ Home Phone _____ Mobile _____
Employer Name: _____ City: _____

Primary Insurance (Please provide insurance card for us to copy) Co-Pay Amount \$ _____

Name of Insured (as it appears on the card): _____ SS # _____
Relationship to Patient: _____ DOB: _____ Contract ID# _____
Employer Name: _____ City: _____

Secondary Insurance (Please provide insurance card for us to copy) Co-Pay Amount \$ _____

Name of Insured (as it appears on the card): _____
Relationship to Patient: _____ DOB: _____ Contract ID# _____
Employer Name: _____ City: _____

Patient's Legal Name _____
Last First Middle

Age _____ Date of Birth _____ Male Female Occupation _____

Referred by _____ Family Physician _____

PLEASE COMPLETE ALL AREAS INSIDE THIS BOX:

1) Was this an accident: Yes If an accident what Date: _____ No (if no, go to #3)

2) If an accident, please explain how it happened: _____

3) If not an accident, when was the onset of today's condition: _____

4) Specific location of injury or pain: Right _____ Left _____ Location _____

5) Is pain sharp / dull, constant / occasional? _____

6) What are your symptoms? _____

7) On a scale of 1 to 10, 10 being the worst, what is the severity of your pain? _____

8) What activities make the problem feel worse? _____
 or better? _____

9) How long have you experienced this problem? _____

10) If you have had an X-ray, MRI, PT or Injections in the last 60 days for this problem, please list those here: _____

List all medications that you are currently taking (prescription and non-prescription): See attached medication list

Medication Name	Dosage	Times/Day	Medication Name	Dosage	Times/Day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

ARE YOU ALLERGIC TO ANY MEDICATIONS?: Yes No Latex Allergy?: Yes No

List any medications that you are allergic to and the reaction it causes:

ARE YOU OR HAVE YOU BEEN UNDER CARE OF A PAIN CLINIC? Yes No

DO YOU HAVE A HISTORY OF BLOOD CLOTS OR DVT? Yes No

Prior Surgeries: _____

ROS Please check all CURRENT positive findings that apply to you or mark none.

CONSTITUTIONAL	<input type="checkbox"/> weight loss	<input type="checkbox"/> weight gain	<input type="checkbox"/> loss of appetite	<input type="checkbox"/> weakness	<input type="checkbox"/> NONE
EENT	<input type="checkbox"/> blurry vision	<input type="checkbox"/> hoarseness	<input type="checkbox"/> ringing in ears		<input type="checkbox"/> NONE
CARDIAC	<input type="checkbox"/> chest pain	<input type="checkbox"/> irregular heartbeat	<input type="checkbox"/> swelling in the legs or feet		<input type="checkbox"/> NONE
RESPIRATORY	<input type="checkbox"/> pain when breathing	<input type="checkbox"/> shortness of breath			<input type="checkbox"/> NONE
GASTROINTESTINAL	<input type="checkbox"/> liver problems	<input type="checkbox"/> blood in stool	<input type="checkbox"/> gallbladder problems		<input type="checkbox"/> NONE
GENITOURINARY	<input type="checkbox"/> bladder problems	<input type="checkbox"/> incontinence	<input type="checkbox"/> pain with urination	<input type="checkbox"/> kidney stones	<input type="checkbox"/> NONE
INTEGUMENTARY	<input type="checkbox"/> rashes	<input type="checkbox"/> skin ulcers	<input type="checkbox"/> changes in skin		<input type="checkbox"/> NONE
NEUROLOGICAL	<input type="checkbox"/> headaches	<input type="checkbox"/> numbness/tingling	<input type="checkbox"/> seizures	<input type="checkbox"/> dizziness <input type="checkbox"/> faintness	<input type="checkbox"/> NONE
MENTAL HEALTH	<input type="checkbox"/> depression	<input type="checkbox"/> sleep disorder	<input type="checkbox"/> nervousness	<input type="checkbox"/> fainting spells	<input type="checkbox"/> NONE
HEMATOLOGIC	<input type="checkbox"/> easy bleeding	<input type="checkbox"/> easy bruising	<input type="checkbox"/> bleeding problems		<input type="checkbox"/> NONE
ENDOCRINE	<input type="checkbox"/> thyroid problems	<input type="checkbox"/> low blood pressure	<input type="checkbox"/> thirst		<input type="checkbox"/> NONE
MUSCULOSKELETAL	<input type="checkbox"/> joint pain	<input type="checkbox"/> muscle pain	<input type="checkbox"/> cramps	<input type="checkbox"/> limitation in motor activity	<input type="checkbox"/> NONE

HISTORY Please check all that apply (Family refers to parents, brothers, sisters, or children)

Condition	You	Family	Condition	You	Family	Condition	You	Family
Jaundice or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Cancer Type _____		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>			

Have you ever been diagnosed/treated for any other conditions/illness not listed above _____

Women: Are you pregnant? Yes No Date of last menstrual period: _____

SOCIAL HISTORY:

Do you smoke? Yes No # of Years _____ Packs per day _____

Do you drink alcoholic beverages? Yes No Drinks per week _____

Marital Status: Married Single Divorced Widowed Number of Children _____

Occupation: _____ Currently Working: Yes No

I hereby certify by my signature that the medical information given on this form is correct to the best of my knowledge.

Patient Signature _____ Date _____

DO NOT SIGN BELOW UNLESS ASKED TO UPDATE YOUR FORM DURING A RETURN VISIT

I hereby certify that I have reviewed and updated the medical information on this form and it is currently accurate.

Patient Signature - Update # 1	Date	Physician Signature - Update # 1	Date
Patient Signature - Update # 2	Date	Physician Signature - Update # 2	Date
Patient Signature - Update # 3	Date	Physician Signature - Update # 3	Date

PHYSICAL EXAMINATION: Patient Name: _____ DOB: _____

Vital Signs: B/P _____ P _____ R _____ T _____ Height _____ Weight _____

	Within Normal Limits		Findings
	Yes	No	
HENT	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Data _____			

IMPRESSION/DIAGNOSIS: _____

PLAN: _____

The patient has been advised of the plan and/or procedure, including the potential risks and benefits, and agrees to proceed.

Physician Signature _____ Date _____

GUARANTEE OF ACCOUNT

The Orthopaedic Center (TOC) requests payment for co-pays and deductibles at time of service. Your contract with your insurance carrier, depending on the type of insurance and the carrier, states that you are responsible for co-pays and deductibles at the time of service and TOC also has an agreement with your carrier to collect such fees at time of service. If your carrier has not paid your account with TOC within 60 days we ask that you pay the balance and seek settlement direct from your carrier.

If you are not covered by health insurance please ask the TOC personnel about a possible reduction in your fee for a cash payment at time of service.

If you have some other extenuating circumstance that leaves you unable to pay please ask the TOC personnel about possible resolution of debt.

I hereby authorize and assign payment directly to The Orthopaedic Center and each physician in the Group individually for any medical/surgical benefits, injury benefits due because of third party liability, or proceeds of all claims resulting from the liability of the third party until such time as the account is paid in full upon the completion of treatment.

By signing this form, I accept responsibility for reasonable costs incurred if my account becomes delinquent. I have read, understand and agree with the above.

X _____

Signature of Patient and/or Authorized Representative

_____ Date

PATIENT SIGNATURE AUTHORIZATION / RELEASE OF INFORMATION

I hereby consent to and authorize TOC to furnish any insurance company, organization, hospital, physician or pharmacist any information requested with respect to any physical or mental condition and/or treatment of me or my child.

I understand the information obtained by this authorization will be used to determine eligibility for insurance and eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize.

I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

X _____

Signature of Patient and/or Authorized Representative

_____ Date

CONSENT FOR MEDICAL / EMERGENCY TREATMENT

I hereby consent to and authorize TOC personnel or its contractors to render usual and customary medical/emergency treatment to me. I understand the treatment provided will be in accordance with the standard of care at the time the care is provided, including but not limited to office visits, surgical procedures and interpretations of x-rays and MRIs.

X _____

Signature of Patient and/or Authorized Representative

_____ Date

_____ Witness

**ACKNOWLEDGEMENT TO USE AND DISCLOSE HEALTH INFORMATION FOR
TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS**

I understand and have been offered a TOC Notice of Privacy Practices that provides a more complete description of information uses and disclosures; that I have the right to review the notice prior to signing this acknowledgement; that TOC reserves the right to change its notice and practices.

X _____

Signature of Patient and/or Authorized Representative

_____ Date

_____ Witness

Good faith attempt has been made to provide the patient with our Notice of Privacy Practices.

_____ TOC Employee Signature

_____ Date

_____ Witness

PAYMENT OF MEDICARE BENEFITS TO PROVIDER EXTENDED AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made directly to The Orthopaedic Center on my behalf.

X _____

Signature of Patient and/or Authorized Representative

_____ Date

_____ Witness

PAYMENT OF MEDICAID BENEFITS TO PROVIDER EXTENDED AUTHORIZATION

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the State of Alabama and/or Tennessee or its fiscal agents any information needed for this or a related Medicaid claim. I request that payment of authorized benefits be made directly to The Orthopaedic Center on my behalf.

X _____

Signature of Patient and/or Authorized Representative

_____ Date

_____ Witness

ADDITIONAL PERSON AUTHORIZATION

Purpose: To ensure authorization that releases TOC to speak with additional persons regarding patient care.

I, _____, patient of TOC authorize the following individuals to be able to discuss my care and/or appointments at The Orthopaedic Center with my attending physician and clinical staff, as well as any insurance or billing issues.

_____ Name

_____ Relationship

_____ Name

_____ Relationship

_____ Name

_____ Relationship

_____ Name

_____ Relationship

X _____

Signature of Patient and/or Authorized Representative

_____ Date

_____ Witness

As a patient of The Orthopaedic Center, P.C., you should be aware that you may be referred to a health care facility with whom physicians of The Orthopaedic Center, P.C. may have an ownership, investment and/or financial relationship. You are, however, free to choose to obtain health care services elsewhere from another provider of your choice, and you may request to be provided with a list of alternative providers, if any, that may be available. You will not be treated differently by The Orthopaedic Center, P.C. regardless of whether you choose to obtain health care services elsewhere.

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently.