

Today's Date: _____

PATIENT INFORMATION

Last Name: _____ First: _____ Mi. Init: _____

DOB: _____ Age: _____ SSN: _____ Gen: M F Marital Status: S M D W

Race: African American American Indian Asian Caucasian Hispanic Pacific Islander Other

Address: _____ City: _____ State: _____ Zip: _____

Preferred phone #: _____ Secondary Phone #: _____
select: CELL HOME WORK *select:* CELL HOME WORK

Email address: _____

Occupation: _____ Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Employer Contact Person: _____ Phone #: _____

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____

Preferred phone #: _____ Secondary phone #: _____
select: CELL HOME WORK *select:* CELL HOME WORK

VISIT INFORMATION

Reason for appointment: _____ Date symptoms began: _____

Primary Care Physician: _____ City: _____

Referring Physician (*if other than PCP*): _____ City: _____

Preferred Pharmacy: _____ City: _____ Phone #: _____

HEALTH INSURANCE

Primary Insurance: _____ Policy #: _____ Group ID #: _____

Who is the insurance policy holder? Self Spouse Parent Other _____

If not "self"...

Policy Holder's Name: _____ DOB: _____ SSN: _____

Policy Holder's Employer: _____ Employer Phone #: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance: _____ Policy #: _____ Group ID #: _____

Who is the insurance policy holder? Self Spouse Parent Other _____

If not "self"...

Policy Holder's Name: _____ DOB: _____ SSN: _____

GUARANTOR/LEGAL GUARDIAN (if applicable)

Parent Legal Guardian Other Name: _____ DOB: _____
SSN: _____ Relationship to patient: _____ Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____

WORKERS' COMP INFORMATION (if applicable)

Is this a work-related injury? YES NO Did you report it? YES NO Did your employer approve this visit? YES NO

Date/Time of injury: _____ Part of body injured: _____

Contact person at place of employment: _____ Date last worked: _____

Workers' Compensation Carrier: _____ Claim #: _____

Address: _____ City: _____ State: _____ Zip: _____

Adjuster's Name: _____ Phone #: _____

ACCIDENT/PERSONAL INJURY INFORMATION (if applicable)

Is this a motor vehicle/personal injury? YES NO Date/time of accident: _____ State accident occurred: _____

Insurance Carrier: _____ Claim #: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

ATTORNEY INFORMATION (if applicable)

Attorney's name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

HOW DID YOU LEARN ABOUT PARKVIEW? (Please be specific.)

- | | |
|---|--|
| <input type="checkbox"/> Family/Friend | <input type="checkbox"/> Physician (who?): _____ |
| <input type="checkbox"/> Have been our patient in the past | <input type="checkbox"/> Hospital or Urgent Care (which one?): _____ |
| <input type="checkbox"/> Internet search | <input type="checkbox"/> Coach/Trainer (who?): _____ |
| <input type="checkbox"/> Facebook | <input type="checkbox"/> Health Fair (where/when?): _____ |
| <input type="checkbox"/> Insurance Company | <input type="checkbox"/> Physician lecture (where/when?): _____ |
| <input type="checkbox"/> Workers' Comp case manager or attorney | <input type="checkbox"/> Other (specify): _____ |

All of the information provided is complete and accurate to the best of my knowledge.

PATIENT SIGNATURE

DATE

YOUR PHOTO ID, INSURANCE CARD, AND COPAY ARE REQUIRED AT THE TIME OF THE VISIT. IF YOU DO NOT HAVE YOUR INSURANCE CARD AVAILABLE, ALL CHARGES WILL BE YOUR RESPONSIBILITY AND PAYABLE AT THE TIME OF SERVICE. OBTAINING ANY REQUIRED REFERRAL FORMS IS YOUR RESPONSIBILITY, AS ARE ALL UNPAID BALANCES AND/OR DENIED CLAIMS.

Today's Date: _____

Name _____ Date of Birth _____

If you are currently under the care of another physician, please provide his/her name and specialty:
PHYSICIAN
SPECIALTY (What do you see him/her for?)

_____	_____
_____	_____
_____	_____

Please list any medications/drugs you are currently taking. (Include any over-the-counter medicine, vitamins, etc.)
NAME OF MEDICINE
DOSAGE
TIMES PER DAY

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list ALL allergies you have. (Including medications, environmental allergies, etc.)

Please check any of the following conditions for which you have ever been treated:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Tumor or cancer | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Blood disease or anemia | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Disabling headaches | <input type="checkbox"/> Polio | <input type="checkbox"/> Gallbladder trouble |
| <input type="checkbox"/> Nervous disorder | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Stomach trouble or ulcers | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Rectal bleeding | <input type="checkbox"/> Goiter or thyroid trouble | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood pressure trouble | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Dislocation | <input type="checkbox"/> Heart trouble |
| <input type="checkbox"/> Back pain/disorder | <input type="checkbox"/> Broken bone | <input type="checkbox"/> Albumen or sugar in urine | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Foot trouble | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Calf pain |

DETAILS of any conditions that you selected above:

Please list all previous surgeries, including the year and the name of your physician:

<u>SURGERY</u>	<u>YEAR</u>	<u>NAME OF PHYSICIAN</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

Do you smoke tobacco? Never smoker Current every day smoker Years smoked: _____
 Former smoker Current occasional smoker Packs per day: _____

Do you consume alcohol? YES NO If yes, approximate number of drinks per week: _____

Do you use recreational drugs? YES NO

Please list any additional information that you feel is important for your doctor to know:

Patient Signature: _____ Date: _____

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by **Parkview Orthopaedic Group** (the Practice) and its employees or designees. I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs. **INITIAL:** _____

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION (PHI). I authorize use and disclosure of my PHI for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. The Practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. **INITIAL:** _____

I authorize the Practice to release information about my medical condition to the following people:

Name: _____ **DOB:** _____ **Relationship:** _____

Name: _____ **DOB:** _____ **Relationship:** _____

PATIENT COMMUNICATIONS. I consent to be contacted by the Practice or anyone calling on its behalf for any reason, including appointment reminders and past due patient balances. I authorize the Practice to contact me at any telephone number or physical or electronic address I provide. I agree that the Practice may contact me in any way, including calls or text messages delivered by an automatic telephone dialing system, or email messages delivered by an automatic emailing system. I agree to promptly notify the Practice at any time my contact information changes. **INITIAL:** _____

CANCELLATION/NO-SHOW POLICY: I understand that the Practice requires a 24-hour advance notification for the cancellation of a scheduled appointment for a physician, physical therapy, x-ray, MRI, etc. This allows the Practice to accommodate other patients seeking appointments. I understand that if I cancel an appointment without 24-hour notice, or fail to show for my scheduled appointment, I will be subject to a fee of \$50.00. I know that my physician has no discretion regarding the matter. **INITIAL:** _____

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE. I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney's fees. **INITIAL:** _____

PRIVACY POLICY. I acknowledge having received the Practice's "Notice of Privacy Practices." My rights, including the rights to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the practice has already made disclosures with my prior consent. **INITIAL:** _____

PRINT NAME (Patient or Authorized Person who is signing consent)

RELATIONSHIP (if not patient)

Signature: _____ **Date:** _____

If patient is unable to sign, verbal consent may be given. Reason: _____

Witness Signature: _____ **Date:** _____