ADVANCED ORTHOPEDICS
& Joint Preservation

Patient's Intake Workers Compensation

Dr./ PA________________

REFFERD BY:_____________________ **TODAY'S DATE:**________________

FULL NAME: ____ HOME PH # (   )________________
LAST FIRST MI

ADDRESS: ____ CELL PH # (   )__________________
Appointment text message reminder

____ WORK PH # (   )________________
CITY STATE ZIP

D.O.B ________/_______/_______ SOC SEC#_________-_______-__________ GENDER ☐ M ☐ F
MM DD YYYY (We need your SSN in order to process your WC claim)

Primary Care Dr: ____ MARTIAL STATUS: S M D W
Name Phone

RACE: (check one) White - Black - Asian - American Indian - Unknown - Other:________________

PREFFERED LANGUAGE: ☐ English ☐ Spanish ☐ Russian ☐ Other:______________________

Ethnicity: (check one) ( ) Hispanic or Latino ( ) Not Hispanic or Latino ( ) Unknown

PREFFERED PHARMACY (NAME & LOCATION):____

Employment at time of accident:____

Email Address:________________@____________.COM DATE OF WC ACCIDENT:_____/_____/________
Email appointment reminder/ Patient Portal

WORKERS COMP INSURANCE INFORMATION

INSURANCE: ____ CLAIM #:________________________
Carrier name

ADDRESS: ____ Phone #: ________________________

POLICY HOLDER: ____
name Relationship

ADJUSTER:____
Name Address Phone/Fax

ATTORNEY/FIRM:____
Name Address Phone/Fax

MAJOR MEDICAL INSURANCE INFORMATION

(Please provide us your private insurance in case your claim is denied, otherwise you will be fully responsible in its entirety)

INSURANCE PLAN NAME: ____________________________________ INS. GROUP #:_________________

ADDRESS: ____ INS. ID #: ______________________

____ PHONE # ______________________
CITY STATE ZIP

POLICY HOLDER: ____
Name (Last, first) Date of Birth SSN

RELATIONSHIP TO PATIENT: ☐ SELF ☐ CHILD ☐ SPOUSE ☐ Other _________________________

INITIAL:_______ **Female patients if you are pregnant or think you may be pregnant please let us know IMMEDIATELLY.**

Medical History

Was this a? ☐Job Related ☐Car Accident ☐Other Injury: ______________________________________

Did *you* receive medical attention? ☐**Yes** ☐**No** **Where?**_____________________________________

Describe how *you* were injured:____

____

____

What body Parts are you here for? ☐ **Right** ☐ **Left** ☐**Bilateral**

☐**Shoulder** ☐**hand** ☐**Elbow** ☐**back** ☐**Hip** ☐**Knee** ☐**Foot** ☐**Ankle** ☐**other:** ________________

____

____

Have you ever had *prior surgery* or *broken bones* or prolonged illness? ☐ **Yes** ☐ **No**

Date________________ Procedure ____

Hospital: ____Dr. Name __________________________

Date________________ Procedure ____

Hospital: ____Dr. Name __________________________

Please answer yes or no to any Illness you may have had or have now.

Pace Maker or Stent					
High Cholesterol	☐ **Yes**	☐ **No**	Rheumatoid Arthritis	☐ **Yes**	☐ **No**
Alcohol Abuse	☐ **Yes**	☐ **No**	Osteoarthritis	☐ **Yes**	☐ **No**
Constipation	☐ **Yes**	☐ **No**	Arthritis	☐ **Yes**	☐ **No**
High Blood Pressure	☐ **Yes**	☐ **No**	Osteoporosis	☐ **Yes**	☐ **No**
Kidney Problems	☐ **Yes**	☐ **No**	Asthma	☐ **Yes**	☐ **No**
Bleeding Tendencies	☐ **Yes**	☐ **No**	Urinary Problems	☐ **Yes**	☐ **No**
Diabetes	☐ **Yes**	☐ **No**	Thyroid	☐ **Yes**	☐ **No**
Cancer	☐ **Yes**	☐ **No**	Neurological Problems	☐ **Yes**	☐ **No**

Social History

Do you smoke? ☐ **Yes** ☐ **No** How many packs/cigarettes per day? ___________________

Do you use Alcohol? ☐ **Yes** ☐ **No** Socially * Occasionally * Other _________________

Any use of illicit drugs? ☐ **Yes** ☐ **No** If Yes Explain: ________________________________

In case of EMERGENCY please list name of person we can contact.

Name_____________________________ Relationship ________________Phone#(____)______-_________

Please answer Yes or No If answer is yes please tell us who.

(Mom, Dad Aunt Grandpa Self etc...)

			Who?				Who?
CANCER	☐ **Yes**	☐ **No**		HEART DIEASE	☐ **Yes**	☐ **No**	
DIABETES	☐ **Yes**	☐ **No**		KIDNEY DISEASE	☐ **Yes**	☐ **No**	
HEPATITIS	☐ **Yes**	☐ **No**		DEPRESSION	☐ **Yes**	☐ **No**	
STROKE	☐ **Yes**	☐ **No**		ASTHMA	☐ **Yes**	☐ **No**	
HYPERTENSION	☐ **Yes**	☐ **No**		Other: ________________________________			

Are you ALLERGIC to any medications? ☐ Yes ☐ No

List____

Are you ALLERGIC to LATEX or RUBBER? ☐ Yes ☐ No

Any other known allergies? ☐ Yes ☐ No

List____

Are you Diabetic? ☐ Yes ☐ No

Diabetics please inform us if you are taking pills or insulin ____ ☐ Yes ☐ No

Prescription Medications/ Over The Counter

Are you taking any medication? ☐ Yes No **If yes please write the name/s below**

Prescription/ Over The counter		NAME	DOSEGES	Times per day
1.				
2.				
3.				
4.				
5.				
6.				

I acknowledge that all the information on this form is true and correct

IS THERE ANYTHING ELSE THAT YOU WOULD LIKE TO TELL YOUR PROVIDER:_______________________________

____

CONSENT TO ACCESS THE NATIONAL RXHUB

I have agreed to allow Advanced Orthopedics and Joint preservation's to access my current list of medications via the National RxHub.

X____/______/_______

SIGNATURE **(parent or legal guardian if patient is a minor)** **NAME IF NOT PATIENT** **DATE**

WC Accident Questionnaire (MUST BE FILLED OUT IN FULL)

We cannot process your claim without this form

INJURED Name:____/_____/________
LAST FIRST DATE OF ACCIDENT

Employment at time of accident: ____

Employer phone #: _______________________________ Job duties:____

Insurance Carrier Name ____ WCB.# _____________________

ACCIDENT DETAILS:

Place of accident (plant, office, etc.) ____

Address: ____
City state zip

Did *you* report the accident to your employer? ☐**Yes** ☐**No** If yes,

When? ___________ To Whom? _____________ What is/was their position with your employer? _______________

Job Duties:

____

Describe how *you* were injured:____

____

____

What parts of your body were injured? ☐ **Right** ☐ **Left**

____

Did *you* have any broken bones from this accident? ☐ **Yes** ☐ **No**

If yes, which bones were broken? ____

Did *you* receive medical attention at the scene of the accident? ☐ **Yes** ☐ **No**

Where did *you* go immediately following the accident?

☐ Hospital ☐ Personal Doctor ☐ This office ☐ Home ☐ Resumed daily activities

Location:____

Please describe how you felt immediately after the injury: ____

What are your present complaints and symptoms? ____

____

Have you seen another physician for this condition? ❒ yes ❒ no Doctor's Name: ________________________

Were x-rays taken? ❒yes ❒no ***MRI?*** ❒yes ❒no

If yes, please list facility where taken:____

Body parts: ____ ❒ Right ❒ Left

Are you currently working? ☐ **Yes** ☐ **No**

☐ Full duty ☐ Light duty ☐ Not working due to this injury ☐ Retired

If not working, when do you intend to return? _________________________________

Signature: ____ ***Today's date:*** ______/_______/_______

ADVANCED ORTHOPEDICS & Joint Preservation

Assessment Form

Doctor/PA______________________

Patient's Name____ **Today's Date** _____ /_____ / _____

Age: ________ Weight: ________ Height:_________ ❒ Right Handed ❒ Left Handed

Reason for evaluation:____

Body parts: ❒ Right ❒ Left ❒B/L

❒ Hip ❒ Knee ❒Ankle ❒ Back ❒Shoulder ❒Elbow ❒Arm ❒hand ❒Other ______________________

Date Of Injury: ______/______/__________

How long have *you* had the pain? 1 2 3 4 5 6 7 8 9 10 11 12
Hours / Days / Weeks / Months / Years

Was this a ☐ Job Related ☐ Car Accident ☐ Other Injury: _________________

Did *you* receive medical attention? ☐ Yes ☐ No

Describe how *you* were injured:____
____

Are You in pain? ☐No ☐ Yes

Frequency of pain: ❒Constant ❒ Intermittent ❒ Infrequent ❒ Rare ❒ Seldom

Quality of Pain: ❒Aching ❒ Cramping ❒ Dull ❒ Numbing ❒Pins & needle ❒ Sharp
❒ Shooting ❒ Stabbing ❒ Tingling ❒ Throbbing ☐ None

Radiation:____

Severe Pain at its ***worse:*** 0/10 1/10 2/10 3/10 4/10 5/10 6/10 7/10 8/10 9/10 10/10

Severe Pain at its ***best:*** 0/10 1/10 2/10 3/10 4/10 5/10 6/10 7/10 8/10 9/10 10/10

Severe Pain ***right now:*** 0/10 1/10 2/10 3/10 4/10 5/10 6/10 7/10 8/10 9/10 10/10

What makes it worse? __________________________Relieving factors:____________________________

Any other associated Systems? ____

Any History of fall? ☐ **Yes** ☐ **No** History of Fibromyalgia? ☐ **Yes** ☐ **No**

Are you currently using any supporting devices? ☐ **No**

☐ **cane** ☐ **crutches** ☐ **walker** ☐ **wheelchair** ☐ **Orthotic device**

Are you *currently* going to Physical therapy? ❒yes ❒no

How many times a week? ________________ Doctor's Name:_______________________

Signature: ____ ***Today's date:*** _____/_____/______

ADVANCED ORTHOPEDICS
& Joint Preservation

PATIENT NAME:___________________________________ DATE:_____/______/______

CONSET TO TREAT

This information I have given this office is complete and true to the best of my knowledge. I authorize the doctors and staff of Advanced Orthopedics and Joint Preservation to administer such procedures and treatment as they deem necessary. They have implied no guarantee to cure.

Patients Initial :______________ **Date**:______/_______/_______

CONSET TO TREAT A MINOR

The information I have given this office pertaining to __________________________ is true and complete to the best of my knowledge. I authorize the doctors and staff of Advanced Orthopedics and Joint Preservation PC, to administer such procedures and treatment as they seem necessary to my child/ward in my legal custody. The doctors have implied no guarantee of cure.

Patients Initial :______________ **Date**:______/_______/_______

FOR WOMEN ONLY

The doctors and staff members of Advanced Orthopedics and Joint Preservation PC, has advised me that x-rays can be hazardous to an unborn child. At this time and the best of my knowledge, I am not pregnant. I consent to have an x-ray taken.

Patients Initial :______________ **Date**:______/_______/_______

PAYMENT AGREEMENT/ASSIGNMENT OF BENEFITS

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse the issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

A photocopy of this assignment shall be considered as effective and valid as the original.
I authorize the release of information pertinent to my case to my insurance company, claims adjuster or attorney involved in this case.
I hereby instruct and direct my insurance company to directly reimburse my provider for charges incurred on my behalf. Please remit payment directly to:

ADVANCED ORTHOPEDICS AND JOINT PRESERVATION

PATIENTS SIGNATURE:____ DATE:________________________

GUARDIAN SIGNATURE:____ **DATE:**___________________________________

HIPPA PRIVACY NOTICE ACKNOWLEDGEMENT

I, ____, acknowledge that I have been provided with a copy of "Advanced Orthopedics and Joint Preservation PC HIPPA Privacy Notice". I would like to authorize the following parties to have access to my
Protected health information____

Due to the new HIPPA LAW we are not allowed BY LAW to disclose any information pertaining to your medical condition, unless you authorize that information to be given.

Do we have your permission?

Leave a message on your answering machine at home/cell phone/email/fax or with a family member? ❒yes ❒no

CONSENT TO ACCESS THE NATIONAL RXHUB

I have agreed to allow Advanced Orthopedics and Joint preservation's to access my current list of medications via the National RxHub.

SIGNATUE:____ DATE:________/__________/_________

ADVANCED ORTHOPEDICS
& Joint Preservation

Today's Date:_______________

PATIENT NAME: ____/______/_________
Last First Date of Birth

HIPPA PRIVACY NOTICE ACKNOWLEDGEMENT

Due to the new HIPPA LAW we are not allowed BY LAW
To disclose any information pertaining to your medical condition,
Unless you authorize that information to be given.

Do we have your permission?

-Leave a *message* on your *answering machine*
at home / cell / phone / email / fax? ❒YES ❒NO

-Leave a *message* with a *family member*? ❒YES ❒NO

Appointment Reminder

(please provide us with your ***cell Phone*** # and ***email*** address so we can send you upcoming appointment reminder's)

Do we have your permission to send you appointment reminders? ❒yes ❒no

Text Message

Cell Phone #__(__________)_____________-______________________

Email

Email address______________________________@_____________________.com

SIGNATUE:_____________________________________ **DATE:**_______/_________/________