ADVANCED ORTHOPEDICS & Joint Preservation

Patient Demographics Private

Doctor/PA:_____

REFFERD BY:_____ **TODAY'S DATE:**_____

FULL NAME: _____ HOME PH #( )_____
LAST FIRST MI

ADDRESS: _____ CELL PH #( )_____

_____ WORK PH #( )_____
CITY STATE ZIP

D.O.B _____/_____/_____ SOC SEC#_____-_____-_____ GENDER ☐ M ☐ F
MM DD YYYY

MARTIAL STATUS: S M D W Primary Care physician _____
FIRST LAST (NPI)

RACE: ☐White ☐Black ☐Asian ☐American Indian ☐Unknown ☐Decline to specify ☐Other:_____

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

PREFFERED PHARMACY (NAME & LOCATION):_____
(If don't remember, please include cross street and town name)

EMPLOYER/SCHOOL:_____

Email Address:_____@_____.COM DATE OF ACCIDENT: _____/_____/_____

PRIMARY INSURANCE POLICY

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 _____

SECONDARY INSURANCE POLICY (IF APPLICABLE)

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 _____

Female patients if you are pregnant or think you may be pregnant please let us know IMMEDIATELLY

Medical History

Accident Information

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

Did *you* receive medical attention? ☐ **Yes** ☐ **No** **Date of Accident:**_____/_____/_____

Describe how *you* were injured:_____

_____

_____

What are your present complaints and symptoms? _____

_____

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

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

_____

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

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	☐ **Yes**	☐ **No**	Heart Problems	☐ **Yes**	☐ **No**
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 per day? _____

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

Any use of illicit drugs? ☐ **Yes** ☐ **No**

Patient Initial: _____

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 none allergies? ☐ Yes ☐ No

List_____

Are you Diabetic? ☐ Yes ☐ No

Diabetics please inform us if you are <u>taking pills or insulin</u> ☐ Yes ☐ No

<u>Prescription Medications/ Over The Counter</u>

(Please write **NONE** if not taking any medication

	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

X_____/_____/_____

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

Assessment Form

Doctor/PA_____

Patient's Name_____ /_____ /_____
Last First 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

Pain Assessment (circle one)

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? ☐ **Yes** ☐ **No**
☐ **cane** ☐ **crutches** ☐ **walker** ☐ **wheelchair** ☐ **Orthotic device**

Are you working? ☐ **Yes** ☐ **No**
☐ Full duty ☐ Light duty ☐ Not working due to this injury ☐Retired
If not working, when do you intend to return? _____

Are you *currently* going to Physical therapy? ❒ yes ❒ no
How many times a week? _____ Doctor's Name:_____
Body parts: _____ ❒ Right ❒ Left

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

ADVANCED ORTHOPEDICS & Joint Preservation

Today's Date:_____

Last Name _____ First Name_____ D.O.B _____/____/_____

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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:_____/_____/_____