Date: _____ Dr: _____ Chart #: _____

TOC The Orthopaedic Center

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 # ( ) _____

Race: _____ Ethnicity: ☐ Non Hispanic or ☐ Hispanic Language: _____

Pharmacy _____ Phone No. _____

Employer Name: _____ City: _____

Emergency contact (not living with you):

Name: _____ Relationship to Patient: _____

Work Phone _____ Home Phone _____ Mobile _____

Place of Injury ☐ **Work** ☐ **Auto** ☐ **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? Yes ☐ **No** ☐ **If Yes, date of injury** _____

Responsible Party IF DIFFERENT FROM PATIENT

Name: _____ Relationship to Patient: _____ ☐M ☐F

DOB: _____ SS# _____ Address _____

Work Phone _____ Home Phone _____ Mobile _____

Employer Name: _____ City: _____

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

Primary Insurance: _____

Name of Insured (as it appears on the card): _____ SS # _____

Subscriber Name: _____ Relationship to Patient: _____

Date of Birth: _____ Policy# _____ Group # _____

Employer Name: _____ City: _____

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

Secondary Insurance: _____

Name of Insured (as it appears on the card): _____ SS # _____

Subscriber Name: _____ Relationship to Patient: _____

Date of Birth: _____ Policy# _____ Group # _____

Employer Name: _____ City: _____

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TOC The Orthopaedic Center

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

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mail, using any e-mail address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree that the Lender/Creditor may contact me/us as described above.

X_____ _____ _____

Signature of Borrower/Customer | 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.

* X X X X X P G 1 *

Today's Date: ______________

Patient's Legal Name: ______________________________

Age: __________ Gender:_____________ DOB:_____________ Height:______ Weight: ______

Referred by: __________________________ Family Physician:__________________________

1. *Specific location of injury or pain:* ______Right ______Left *Body Part:* ________________________________
2. *Was this an accident?* ______ Yes ______ No (If "No", skip to #5)
3. *If an accident, please explain how it happened:*

____

4. *What was the date of the accident?* ____/____/____ *Where did it occur?* ________________________________
5. *If not an accident, how long have you experienced this problem?* ________________________________
6. *Describe the quality of your pain* (ex: Sharp, Dull, Constant, Occasional) ________________________________
7. *What are your symptoms?* ____
8. *On a scale of 1 to 10 (10 being the worst), what is the severity of your pain?* _____________
9. *What activities make the problem feel worse?* ____
10. *What makes the problem feel better?* ____
11. *What tests/procedures you have had in the last 60 days for this problem?* (ex: xray, MRI, CT, injection)

____

12. *Where was the test done?* ____

MEDICAL HISTORY: If you have any of the following, PLEASE FILL IN THE OVAL COMPLETELY:

○ **ADD/ADHD**	○ **Cancer : Colon**	○ **Heart Disease**	○ **Rheumatoid Arthritis**
○ **AIDS/HIV**	○ **Cancer : Lung**	○ **Hepatitis / Jaundice**	○ **Scoliosis**
○ **Alzheimer's**	○ **Cancer : Prostate**	○ **High Blood Pressure**	○ **Seizures**
○ **Anemia**	○ **Colitis / Crohn's**	○ **Implantable Defibrillator**	○ **Sleep Apnea**
○ **Asthma**	○ **COPD / Emphysema**	○ **Kidney Disease**	○ **Stomach Ulcers**
○ **Blood Clot/DVT Leg**	○ **Depression / Anxiety**	○ **Lupus**	○ **Stroke**
○ **Blood Clot/Lung**	○ **Diabetes**	○ **Pacemaker**	○ **NONE**
○ **Cancer : Breast**	○ **Drug Abuse**	○ **Psoriasis**	

○ **OTHER:**

Have you, or have you ever been under the care of a pain clinic?	○ **Yes**	○ **No**
Have you received the FLU Vaccine within the past year?	○ **Yes**	○ **No**
Have you received the PNEUMONIA Vaccine within the past year?	○ **Yes**	○ **No**

Preferred Pharmacy:____ **Phone No:** ________________________

Today's Date: _____

Patient's Legal Name: _____ *XXXXXPG2*

SURGICAL HISTORY: If you have any of the following, PLEASE FILL IN THE OVAL COMPLETELY. Also, please list the year.

- ○ Appendectomy
- ○ Arthroscopy : Shoulder
- ○ Arthroscopy : Knee
- ○ Bunionectomy
- ○ Cardiac Stent
- ○ Carpal Tunnel Release
- ○ Gallbladder
- ○ Gastric Bypass
- ○ Heart Surgery
- ○ Hip Replacement
- ○ Hysterectomy
- ○ Knee Replacement
- ○ Mastectomy
- ○ Spinal Surgery
- ○ Stomach Procedure
- ○ Vascular Procedure

○ **OTHER:**

Have you ever received General Anesthesia? ○ Yes ○ No

If Yes, did you have any problems with the Anesthesia? ○ Yes ○ No

If Yes, please explain: _____

MEDICATIONS: If you take any of the following medications, PLEASE FILL IN THE OVAL COMPLETELY.

- ○ Adderall (Dextroamphetamine)
- ○ Ambien (Zolpidem)
- ○ Buspar (Buspirone)
- ○ Celebrex (Celecoxib)
- ○ Celexa (Citalopram)
- ○ Coumadin (Warfarin)
- ○ Cozaar (Losartan)
- ○ Cymbalta (Duloxetine)
- ○ Dilantin (Phenytoin)
- ○ Dolophine/Metadose (Methadone)
- ○ Insulin (Name:_____)
- ○ Flexeril (Cyclobenzaprine)
- ○ Flomax (Tamsulosin)
- ○ Glucophage (Metformin)
- ○ HCTZ (Hydrochlorothiazide)
- ○ Klonopin (Clonazepam)
- ○ Lasix (Furosemide)
- ○ Lexapro (Escitalopram)
- ○ Lipitor (Atrovastatin)
- ○ Lopressor (Metoprolol)
- ○ Lyrica (Pregabalin)
- ○ Mobic (Meloxicam)
- ○ Neurontin (Gabapentin)
- ○ Nexium (Esomeprazole)
- ○ Norco/Lortab/Vicodin/Lorcet
- ○ Norvasc (Amlodipine)
- ○ Percocet
- ○ Plavix (Clopidogrel)
- ○ Pravachol (Pravastatin)
- ○ Prinivil/Zestril (Lisinopril)
- ○ Prozac (Fluoxetine)
- ○ Robaxin (Methocarbamol)
- ○ Skelaxin (Metaxalone)
- ○ Synthroid (Levothyroxine)
- ○ Tenormin (Atenolol)
- ○ Ultram (Tramadol)
- ○ Tylenol (Acetaminophen)
- ○ Valium (Diazepam)
- ○ Xanax (Alprazolam)
- ○ Zocor (Simvastatin)
- ○ Zyrtec (Cetirizine)

NSAIDS (select below)

- ○ Naprosyn/Aleve (Naproxen)
- ○ Motrin/Advil (Ibuprofen)

Vitamin Supplements (list)

_____

○ **NONE**

○ **OTHER:**

ALLERGIES: If you have allergies to any of the following, PLEASE FILL IN THE OVAL COMPLETELY.

- ○ Amoxicillin
- ○ Ampicillin
- ○ Bactrim / Septra
- ○ Cephalosporins (Ceftin / Cefzil / Keflex / Suprax)
- ○ Codeines
- ○ Hydrocodone
- ○ Insulin
- ○ Iodine/Shellfish
- ○ Keflex
- ○ **Latex**
- ○ **Nickel/Metal**
- ○ Penicillin
- ○ Septra
- ○ Sulfa Drugs
- ○ Tape/Adhesive
- ○ Seasonal Allergies
- ○ **NONE**

○ **OTHER:**

Today's Date: _____

Patient's Legal Name: _____

* X X X X X P G 3 *

SOCIAL HISTORY: PLEASE FILL IN THE OVAL COMPLETELY to answer the following questions.

Do You Currently Use Tobacco? ○ Yes ○ No **Appoximate AGE when you started?** _____

If YES, what type do you use? ○ Smoking ○ Smokeless Vapor ○ Chewing

Packs Per Day? ○ 1 ○ 2 ○ 3 ○ 4 >

Please Select a Smoking Status:

- ○ NEVER smoker
- ○ FORMER smoker
- ○ CURRENT Everyday Smoker
- ○ CURRENT Sometimes Smoker
- ○ LIGHT Tobacco User
- ○ HEAVY Tobacco User
- ○ Current Status Unknown
- ○ Unknown if Ever Smoked

Do you use Alcohol? ○ Yes ○ No **Drinks per Day?** ○ 1-3 ○ 4-6 ○ 7+ ○ Occasional

Marital Status? ○ Single ○ Married ○ Divorced ○ Widowed

Number of Children? ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 >

Hand Dominance? ○ Right ○ Left ○ Ambidextrious

Currently Working? ○ Yes ○ No **OCCUPATION:** _____

FEMALES ONLY: Could you be pregnant? ○ Yes ○ No **Last Menstural Cycle?** _____

FAMILY HISTORY: PLEASE FILL IN THE OVAL COMPLETELY if you have a family member with the following:

○ Unknown / Adopted

	Father	Mother	Brother	Sister	Son	Daughter	Other
AIDS/ HIV	○	○	○	○	○	○	○
Anemia	○	○	○	○	○	○	○
Blood Clots	○	○	○	○	○	○	○
Cancer (Breast)	○	○	○	○	○	○	○
Cancer (Colon)	○	○	○	○	○	○	○
Cancer (Lung)	○	○	○	○	○	○	○
Cancer (Prostate)	○	○	○	○	○	○	○
Coronary Artery Disease	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○
Gout	○	○	○	○	○	○	○
Heart Attack	○	○	○	○	○	○	○
Hemophilia	○	○	○	○	○	○	○
Hypertension	○	○	○	○	○	○	○
Kidney Disease	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○
Muscle Disease	○	○	○	○	○	○	○
Osteoarthritis	○	○	○	○	○	○	○
Osteoporosis	○	○	○	○	○	○	○
Rheumatoid Arthritis	○	○	○	○	○	○	○

Today's Date:_____

Patient's Legal Name: _____

* X X X X X P G 4 *

REVIEW OF SYSTEMS: If you have any of the following PLEASE FILL IN THE OVAL COMPLETELY.

Please make a selection for EACH BOX.

CONSTITUTIONAL	ENDOCRINE	CARDIOVASCULAR	GASTROINTESTINAL
○ Weight Loss / Gain	○ Thyroid Trouble	○ Chest Pain	○ Rectal Bleeding
○ Weakness	○ Low Blood Pressure	○ Irregular Heart Beat	○ Gallbladder Trouble
○ Loss of Appetite	○ Excessive Thirst	○ Swelling of Legs / Feet	○ Liver Problems
○ **NONE**	○ **NONE**	○ **NONE**	○ **NONE**

HEMATOLOGICAL	EENT	INTEGUMENTARY	RESPIRATORY
○ Bleeding Problems	○ Blurred Vision	○ Rashes	○ Shortness of Breath
○ Easy Bleeding	○ Hoarseness	○ Skin Ulcers	○ Pain when Breathing
○ Easy Bruising	○ Ears Ringing	○ Changes in Skin	○ **NONE**
○ **NONE**	○ **NONE**	○ **NONE**	

GENITOURINARY	MUSCULOSKELETAL	MENTAL HEALTH	NEUROLOGICAL
○ Bladder Problems	○ Joint Pain	○ Nervousness	○ Headache
○ Incontinence	○ Cramps	○ Depression	○ Dizziness
○ Kidney Stones	○ Limitation in Activity	○ Sleep Disorder	○ Seizures
○ Burning Urination	○ Muscle Pain	○ Fainting Spells	○ Numbness / Tingling
○ **NONE**	○ **NONE**	○ **NONE**	○ Faintness
			○ **NONE**

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_____

FOR PHYSICIAN USE ONLY:

PHYSICAL EXAMINATION **Vitals Signs** B/P _____ P _____ R _____ T _____

	Within Normal Limits? YES	NO	Findings
HENT	□	□	_____
Eyes	□	□	_____
Neck	□	□	_____
Heart	□	□	_____
Lungs	□	□	_____
Abdomen	□	□	_____
Neurological	□	□	_____
Musculoskeletal	□	□	_____
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/Time**_____