PATIENT DEMOGRAPHICS FORM

Date: _____

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:
Street Address:		
City, State, Zip:		
Home Phone: _____ May we leave a voicemail message? ❑ Yes ❑ No If yes, select type of message: ❑ Brief ❑ Extended	Cell Phone: _____ May we leave a voicemail message? ❑ Yes ❑ No If yes, select type of message: ❑ Brief ❑ Extended	
Date of Birth:	Gender: ❑ Male ❑ Female	
Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated	SSN:	
Email Address:	Preferred Language: ❑ English ❑Spanish ❑ Other	
Who is your family doctor?	Who referred you to Pinnacle?	
Race: (Select one) ❑American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other Race	Ethnicity: (Select one) ❑ Hispanic or Latino ❑ Not Hispanic or Latino	
Please complete if covered under Worker's Comp: Employer Name:	Address: Phone Number:	

INSURANCE INFORMATION

Person Responsible for Bill:	Birth Date:	Home Phone:
Address (if different):		
Primary Insurance Name:		
Subscriber's Name:	Policy #:	Co-pay: $
Subscriber DOB:_____ Subscriber SSN:	Group #:	Group Name:
Patient's Relationship to Subscriber: ❑ Self ❑Child ❑ Spouse ❑ Other		
Secondary Insurance Name:		
Subscriber's Name:	Policy #:	Co-pay: $
Subscriber DOB:_____ Subscriber SSN:	Group #:	Group Name:
Patient's relationship to subscriber: ❑ Self ❑Child ❑ Spouse ❑ Other		

IN CASE OF EMERGENCY

Name of Friend or Relative:	Relationship to Patient:	Contact Number:

PREFERRED PHARMACY

Name: _____ Location:	Phone:	Fax:

Patient Signature: _____ Date: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES & RELEASE AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164)

Patient Name_____ **DOB:** _____

I authorize Pinnacle Orthopaedics & Sports Medicine, LLC to use and/or disclose the Protected Health Information (''PHI'' or personal medical records) described below to: **(Note: this includes releasing prescriptions, medical forms, etc.)**

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Authorization for release of your personal medical record information covering the period of health care.

(Select One) ☐ All of my medical records "PHI" Past, Present and Future Periods OR

☐ From (Date) _____ to (Date)_____.

I hereby authorize the release of my personal medical information as follows:

(Select One)

☐ a. My complete health record "PHI" (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR

☐ b. My complete health record "PHI" *with the exception of the following information* **(circle as appropriate):**

Mental health records — Communicable diseases (including HIV and AIDS)

Alcohol/drug abuse treatment — Other (please specify): _____

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until nine (9) months after my death or _____, (Date) at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices on the date indicated and authorize the release of PHI as described above.

_____ _____

Signature of Patient/Legal Guardian Date

Pinnacle Unencrypted Email & Text Messaging Authorization

Patient Name_____ **DOB:** _____

We offer helpful administrative information by regular text messaging and email, like appointment reminders, medical records request from patient, completed medical forms, etc. There is **some level of risk** that information in a regular text message or email could be read by someone besides you. Please let us know if you would like us to communicate with you by text message and email by answering the follow two questions.

1) ☐ **Yes** – Please communicate with me by email, I understand it is my responsibility to make Pinnacle aware if my email address changes.

☐ **No** – Please do not communicate with me by regular (unencrypted) email.

2) ☐ **Yes** – Please communicate with me by text message, I understand it is my responsibility to make Pinnacle aware if my cell phone number changes.

☐ **No** – Please do not communicate with me via text messaging.

24 Hour Cancellation and "No Show" Administrative Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care or diagnostic testing. Therefore, Effective July 15, 2014, Pinnacle Orthopaedics reserves the right to charge a fee for missed appointments ("no shows") and appointments not cancelled with a 24-hour advance notice.

The following fees will be assessed for no-shows and late cancellations:

Physical Therapy	$ 25.00
MRI and/or Arthrogram	$150.00
Office Visits	$ 25.00
EMG/NCS Test	$ 75.00
Injections/Epidurals within 48-hour notice	$150.00
Surgeries within 48 Hour Notice	$500.00

"No Show" and late cancellation fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" and late cancellations in any 12-month period may result in termination from our practice.

By signing below, you acknowledge that you have received this notice and understand the above policy.

_____ _____

Signature of Patient/Legal Guardian Date

PINNACLE ORTHOPAEDICS & SPORTS MEDICINE SPECIALISTS, L.L.C.

PATIENT ACKNOWLEDGMENT

Patient Name_____ **DOB:** _____

By signing this document below, the patient or responsible party acknowledges they have read and understand the following:

PAYMENT RESPONSIBILITY

Payment for services or the co-payment and/or the co-insurance is payable when service is rendered. Payment for medical services is between Pinnacle Orthopaedics and the patient/responsible party. Therefore, Pinnacle Orthopaedics cannot accept responsibility for collecting or negotiation settlement on any disputed (1) health insurance claim, (2) worker's compensation claim, (3) accidental injury/illness liability claim, (4) claim where patient is or will be represented by an attorney, and/or (5) claim to be settled in a court of law.

Most insurance carriers require a written referral form from a Primary Care Physician in advance of service provided by Pinnacle Orthopaedics. Patients or person responsible for the patient must (1) obtain physician referrals and (2) contact the insurance carrier to verify benefits in advance of service. At the time of service, patients are responsible for payment for non-covered services, deductibles and co-insurance. Patients are also responsible for any penalties imposed by their insurance company for seeing the patient out-of-network. Pinnacle Orthopaedics will file a patient's insurance as a courtesy.

The patient or responsible party certifies that information provided relative to injury, illness, and insurance coverage is both true and correct. By signing this form, the patient or responsible party authorizes payment of insurance benefits or proceeds from any liability claim or legal or court settlement to be assigned to Pinnacle Orthopaedics to the extent that their charges are paid in full.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the physician to release any record, x-rays, and photographs acquired in the course of my treatment to referring physicians, insurance companies, hospitals or surgery centers. I authorize the release of all information necessary to transmit and process claims electronically and/or through any other reasonable and customary means in order to secure payment.

PHYSICIAN ASSISTANTS

Pinnacle Orthopaedics utilizes Physician Assistants in our offices. Physician Assistants may provide care for you during your office visit. By signing this form, you give permission to have Physician Assistants assist in your care.

CONSENT TO TREAT

I hereby volunteer consent to my treatment at Pinnacle Orthopaedics and authorize such treatments, examinations, physical therapy and diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered by my attending /covering physician.

E-PRESCRIBING

Pinnacle Orthopaedics providers utilize e-Prescribing to electronically send an accurate, error free and understandable prescription directly to a pharmacy. By signing below, you are providing your consent for the pharmacy e-Prescription program.

_____ _____

Signature of Patient/Legal Guardian Date

Patient Information Form

Please darken bubbles completely

PATIENT INFORMATION		
Patient Name:	**DOB:**	**Date:**
Height:	**Weight**	

What are you being seen for today? (Only mark 2 body parts per office visit.)

O Neck	O Right Shoulder	O Left Wrist	O Right Knee	O Left Ankle
O Mid Back	O Left Shoulder	O Right Hand	O Left Knee	O Right Foot
O Low back	O Right Elbow	O Left Hand	O Right Calf/Leg	O Left Foot
O Ribs	O Left Elbow	O Right Hip/Thigh	O Left Calf/Leg	Other:
	O Right Wrist	O Left Hip/Thigh	O Right Ankle	_____

How long have symptoms been present or date of injury: _____

How did the pain occur? O Injury O Ongoing Problem O Spontaneous

Is this the result of a motor vehicle accident? O Yes O No

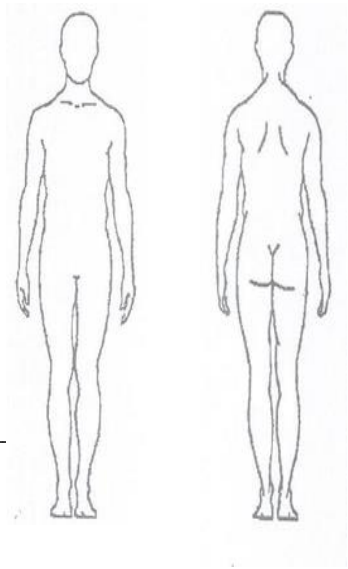
Is this work related? O Yes O No **What is your occupation?** _____

Are you? O Right Handed O Left Handed **(Female) Pregnant:** O Yes O No

Medications: (Please list below the names of medication you are taking and the dosage.) or Check if List Provided ☐		
Allergies: (Please list the medications you are allergic to.)		
Surgeries and Procedures: (Please list the type of surgery or procedure and year.)		
Hospitalizations: (Please list what you were hospitalized for NOT REQUIRING SURGERY and the approximate date.)		

Pain Description:

Place marks in the affected areas:



What is the quality of your pain? O Mild O Moderate O Severe

How would you describe your pain? O Sharp O Dull O Burning

Pain Scale: On a scale of 0 to 10 (0 meaning no pain and 10 meaning worst pain), how would you rate the pain you are currently experiencing?

O 0/10 O 1/10 O 2/10 O 3/10 O 4/10 O 5/10

O 6/10 O 7/10 O 8/10 O 9/10 O 10/10

What makes your symptoms worse? O Standing O Walking O Lifting O Exercise

O Twisting O Lying in Bed O Bending O Squatting O Kneeling O Stairs O Sitting

What makes your symptoms better? O Rest O Elevation O Ice O Heat

Do you have any numbness or tingling? O Yes O No, **If yes, where?** _____

Do you have any weakness? O Yes O No, **If yes, where?** _____

Patient Name: _____ **DOB:** _____

Have you been treated elsewhere for this problem? O Yes O No

If yes, when and by whom? _____

Which of the following treatments have you tried for this problem?

Type of Treatment	Date Started	Made it Worse	No Help	Somewhat Helpful	Very Helpful
Physical Therapy	___/___/____	O	O	O	O
Brace	___/___/____	O	O	O	O
Chiropractic/Massage	___/___/____	O	O	O	O
Anti-Inflammatories	___/___/____	O	O	O	O

(ex: Celebrex, Naproxen, Over-the-counter include Advil, Ibuprofen, Motrin, Aleve, etc.)

List here: _____

If you cannot take anti-inflammatories, list why? _____

Steroids	___/___/____	O	O	O	O

(ex: Medrol Dose Pack, Prednisone, etc.)

List here: _____

Narcotics	___/___/____	O	O	O	O

(ex. Hydrocodone, Oxycodone, Tramadol, etc.)

List here: _____

Muscle Relaxers	___/___/____	O	O	O	O

(ex: Soma, Robaxin, Flexeril, etc.)

List here: _____

Nerve Medication	___/___/____	O	O	O	O

(ex: Neurontin, Lyrica, Elavil, etc.)

List here: _____

Injections	___/___/____	O	O	O	O

What type(s) (trigger point/epidurals/other): _____ Percentage of Relief: _____%

Surgery	___/___/____	O	O	O	O

Have you ever broken a bone from a simple fall or without trauma? O Yes O No

Have you had any of the following diagnostic tests for the body part you are being seen for today?

O - X-Ray O - MRI O - EMG/NCS O - Bone Scan O - CT Scan O - CT Myelogram O - Bone Density Test

When and where did you have the test performed? _____

Do you have any metal in your body? O Yes O No **If yes, where?** _____

Do you use the following? O Cane O Walker O Wheelchair

Medical History – Have you ever had the following?

O	Osteoporosis	O	High Blood Pressure	O	Diabetes	O	Thyroid Disease
O	Arthritis	O	Heart Disease	O	Cancer	O	DVT/Pulmonary Embolism
O	Poor Circulation	O	Irregular Heart Beat	O	Anemia	O	Asthma
O	Epilepsy/Seizures	O	Heart Attack	O	Kidney Disease	O	Emphysema/COPD
O	Stroke	Other : _____					

Infectious Diseases

O	Tuberculosis	O	Lyme Disease	O	Hepatitis	O	MRSA

Please list other infectious diseases you have been diagnosed with: _____

Family History

Mother	O	Cancer	O	Osteoporosis	O	DVT/Pulmonary Embolism	O	Arthritis
Father	O	Cancer	O	Osteoporosis	O	DVT/Pulmonary Embolism	O	Arthritis
Siblings	O	Cancer	O	Osteoporosis	O	DVT/Pulmonary Embolism	O	Arthritis

Patient Name: _____ **DOB:** _____

Social History

Do you smoke cigarettes/cigars? O Yes O No **If yes, how long?** O (<1 year) O (1-10 years) O (10+ years)

If yes, how many packs per day? O less than one O 1 to 2 pks O 3 or more pks

Did you smoke in the past? O Yes O No

Do you chew tobacco? O Yes O No **If yes, how many cans per day?** O less than one O 1 to 2 O 3 or more

Do you drink alcohol? O Yes O No **If yes, how many drinks per day?** O (less than one drink) O (2-3 drinks) O (3+ drinks)

Do you exercise regularly? O Yes O No **If yes, how often?** O (2-3 times/ week) O (3+ times/week)

Do you participate in sports/recreational activities? O Yes O No **If Yes, what activities?** _____

Do you have an Advance Directive? O Yes O No **If yes, please give to front desk to scan or bring to your next visit.**

If No, are you interested in receiving additional information about Advance Directives? O Yes O No

Review of Systems: Are you experiencing any of these symptoms now?

General

O	**Denies All**	O	Fatigue	O	Fever/Chills
O	Weight Change	O	Environmental Allergies	O	Problems w/ Anesthesia

Eyes/Ears

O	**Denies All**				
O	Glasses/Contacts	O	Eye Pain	O	Cataracts
O	Hearing Aids	O	Ringing/Buzzing	O	Eye or Ear Infection

Neurological

O	**Denies All**				
O	Fainting	O	Numbness/Tingling	O	Weakness
O	Headaches	O	Dizziness	O	Blurred/Double Vision

Respiratory

O	**Denies All**				
O	Wheezing	O	Chronic Coughing	O	Shortness of Breath

Cardiovascular

O	**Denies All**	O	Chest Pain	O	Heart Murmur
O	Phlebitis	O	Swelling of feet		

Musculoskeletal

O	**Denies All**	O	Joint Pain/Swelling	O	Joint Stiffness
O	Muscle Pain	O	Back Pain		

Gastrointestinal

O	**Denies All**	O	Diarrhea	O	Ulcers
O	Heartburn	O	Nausea/Vomiting	O	Constipation

Skin

O	**Denies All**	O	Rashes/Sores	O	Itching/Burning

Genitourinary

O	**Denies All**	O	Painful Urination	O	Frequent Urination
O	Blood in Urine				

Hematological

O	**Denies All**	O	Easy Bruising	O	Bleeding Problem

Endocrine

O	**Denies All**	O	Heat Intolerance	O	Cold Intolerance
O	Fatigue				