



# PATIENT DEMOGRAPHICS FORM

Date: \_\_\_\_\_

## INFORMATION PATIENT

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

## INSURANCE INFORMATION

|   |  |             |             |
|---|--|-------------|-------------|
| Person Responsible for Bill:  |  | Birth Date: | Home Phone: |
| Address (if different):   |  |             |             |
| <b>Primary Insurance Name:</b>  |  |             |             |
| Subscriber's Name:  |  | Policy #:   | Co-pay: \$  |
| Subscriber DOB: _____   |  | Group #:    | Group Name: |
| Subscriber SSN:   |  |             |             |
| Patient's Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other |  |             |             |
| <b>Secondary Insurance Name:</b>  |  |             |             |
| Subscriber's Name:  |  | Policy #:   | Co-pay: \$  |
| Subscriber DOB: _____   |  | Group #:    | Group Name: |
| Subscriber SSN:   |  |             |             |
| Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other |  |             |             |

## IN CASE OF EMERGENCY

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

## PREFERRED PHARMACY

|             |        |      |
|-------------|--------|------|
| Name: _____ | Phone: | Fax: |
| Location:   |        |      |

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

\_\_\_\_\_  
Witness (Pinnacle office employee)

\_\_\_\_\_  
Date



Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_

### **Pinnacle Unencrypted Email & Text Messaging Authorization**

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 or email.

☐ **Yes** – Please communicate with me by email. My email address is:

\_\_\_\_\_ 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.

☐ **Yes** – Please communicate with me by text message. My cell phone number is:

\_\_\_\_\_ 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

\_\_\_\_\_  
Witness (Pinnacle office employee)

\_\_\_\_\_  
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

\_\_\_\_\_  
Witness (Pinnacle office employee)

\_\_\_\_\_  
Date

## Patient Information Form

Please darken bubbles completely

### PATIENT INFORMATION

|                      |               |              |
|----------------------|---------------|--------------|
| <b>Patient Name:</b> | <b>DOB:</b>   | <b>Date:</b> |
| <b>Height:</b>       | <b>Weight</b> |              |

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

|                                |                                      |                                       |                                      |                                  |
|--------------------------------|--------------------------------------|---------------------------------------|--------------------------------------|----------------------------------|
| <input type="radio"/> Neck     | <input type="radio"/> Right Shoulder | <input type="radio"/> Left Wrist      | <input type="radio"/> Right Knee     | <input type="radio"/> Left Ankle |
| <input type="radio"/> Mid Back | <input type="radio"/> Left Shoulder  | <input type="radio"/> Right Hand      | <input type="radio"/> Left Knee      | <input type="radio"/> Right Foot |
| <input type="radio"/> Low back | <input type="radio"/> Right Elbow    | <input type="radio"/> Left Hand       | <input type="radio"/> Right Calf/Leg | <input type="radio"/> Left Foot  |
| <input type="radio"/> Ribs     | <input type="radio"/> Left Elbow     | <input type="radio"/> Right Hip/Thigh | <input type="radio"/> Left Calf/Leg  | Other: _____                     |
|                                | <input type="radio"/> Right Wrist    | <input type="radio"/> Left Hip/Thigh  | <input type="radio"/> Right Ankle    |                                  |

**How long have symptoms been present or date of injury:** \_\_\_\_\_

**How did the pain occur?**      ☐ Injury      ☐ Ongoing Problem      ☐ Spontaneous

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

**Is this work related?**      ☐ Yes      ☐ No

**What is your occupation?** \_\_\_\_\_

**Are you?**    ☐ Right Handed      ☐ Left Handed      **(Female) Pregnant:**    ☐ Yes      ☐ 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:

**What is the quality of your pain?**    ☐ Mild      ☐ Moderate      ☐ Severe

**How would you describe your pain?**    ☐ Sharp      ☐ Dull      ☐ 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?

☐ 0/10      ☐ 1/10      ☐ 2/10      ☐ 3/10      ☐ 4/10      ☐ 5/10  
☐ 6/10      ☐ 7/10      ☐ 8/10      ☐ 9/10      ☐ 10/10

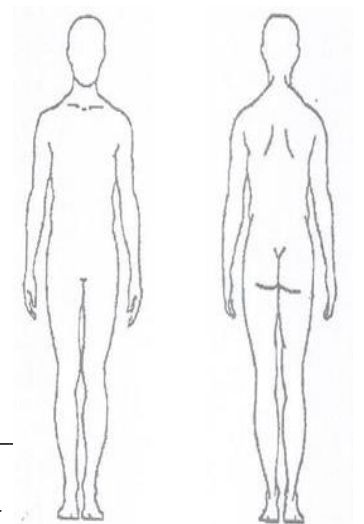
**What makes your symptoms worse?**    ☐ Standing    ☐ Walking    ☐ Lifting    ☐ Exercise  
☐ Twisting    ☐ Lying in Bed    ☐ Bending    ☐ Squatting    ☐ Kneeling    ☐ Stairs    ☐ Sitting

**What makes your symptoms better?**    ☐ Rest    ☐ Elevation    ☐ Ice    ☐ Heat

**Do you have any numbness or tingling?**    ☐ Yes    ☐ No, If yes, where? \_\_\_\_\_

**Do you have any weakness?**    ☐ Yes    ☐ No, If yes, where? \_\_\_\_\_

Place marks in the affected areas:



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Have you been treated elsewhere for this problem?    ☐ Yes                      ☐ 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     | ___/___/___  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Brace                | ___/___/___  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Chiropractic/Massage | ___/___/___  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Anti-Inflammatories  | ___/___/___  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

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

List here: \_\_\_\_\_

**If you cannot take anti-inflammatories, list why?** \_\_\_\_\_

|          |             |                       |                       |                       |                       |
|----------|-------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Steroids | ___/___/___ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|----------|-------------|-----------------------|-----------------------|-----------------------|-----------------------|

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

List here: \_\_\_\_\_

|           |             |                       |                       |                       |                       |
|-----------|-------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Narcotics | ___/___/___ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|-----------|-------------|-----------------------|-----------------------|-----------------------|-----------------------|

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

List here: \_\_\_\_\_

|                 |             |                       |                       |                       |                       |
|-----------------|-------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Muscle Relaxers | ___/___/___ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|-----------------|-------------|-----------------------|-----------------------|-----------------------|-----------------------|

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

List here: \_\_\_\_\_

|                  |             |                       |                       |                       |                       |
|------------------|-------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Nerve Medication | ___/___/___ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|------------------|-------------|-----------------------|-----------------------|-----------------------|-----------------------|

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

List here: \_\_\_\_\_

|            |             |                       |                       |                       |                       |
|------------|-------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Injections | ___/___/___ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|------------|-------------|-----------------------|-----------------------|-----------------------|-----------------------|

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

|         |             |                       |                       |                       |                       |
|---------|-------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Surgery | ___/___/___ | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|---------|-------------|-----------------------|-----------------------|-----------------------|-----------------------|

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

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

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

When and where did you have the test performed? \_\_\_\_\_

Do you have any metal in your body?   ☐ Yes    ☐ No    If yes, where? \_\_\_\_\_

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

**Medical History – Have you ever had the following?**

|   |  |                                      |  |
|---|--|--------------------------------------|--|
| <input type="radio"/> Osteoporosis      | <input type="radio"/> High Blood Pressure  | <input type="radio"/> Diabetes       | <input type="radio"/> Thyroid Disease        |
| <input type="radio"/> Arthritis         | <input type="radio"/> Heart Disease        | <input type="radio"/> Cancer         | <input type="radio"/> DVT/Pulmonary Embolism |
| <input type="radio"/> Poor Circulation  | <input type="radio"/> Irregular Heart Beat | <input type="radio"/> Anemia         | <input type="radio"/> Asthma                 |
| <input type="radio"/> Epilepsy/Seizures | <input type="radio"/> Heart Attack         | <input type="radio"/> Kidney Disease | <input type="radio"/> Emphysema/COPD         |
| <input type="radio"/> Stroke            | Other : _____                              |                                      |  |

**Infectious Diseases**

|                                    |                                    |                                 |                            |
|------------------------------------|------------------------------------|---------------------------------|----------------------------|
| <input type="radio"/> Tuberculosis | <input type="radio"/> Lyme Disease | <input type="radio"/> Hepatitis | <input type="radio"/> MRSA |
|------------------------------------|------------------------------------|---------------------------------|----------------------------|

Please list other infectious diseases you have been diagnosed with: \_\_\_\_\_

**Family History**

|          |                              |                                    |  |                                 |
|----------|------------------------------|------------------------------------|--|---------------------------------|
| Mother   | <input type="radio"/> Cancer | <input type="radio"/> Osteoporosis | <input type="radio"/> DVT/Pulmonary Embolism | <input type="radio"/> Arthritis |
| Father   | <input type="radio"/> Cancer | <input type="radio"/> Osteoporosis | <input type="radio"/> DVT/Pulmonary Embolism | <input type="radio"/> Arthritis |
| Siblings | <input type="radio"/> Cancer | <input type="radio"/> Osteoporosis | <input type="radio"/> DVT/Pulmonary Embolism | <input type="radio"/> Arthritis |

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### Social History

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

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

Did you smoke in the past? ☐ Yes ☐ No

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

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

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

Do you participate in sports/recreational activities? ☐ Yes ☐ No If Yes, what activities? \_\_\_\_\_

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

#### General

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

#### Eyes/Ears

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

#### Neurological

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

#### Respiratory

☐ Denies All  
☐ Wheezing ☐ Chronic Coughing ☐ Shortness of Breath

#### Cardiovascular

☐ Denies All ☐ Chest Pain ☐ Heart Murmur  
☐ Phlebitis ☐ Swelling of feet

#### Musculoskeletal

☐ Denies All ☐ Joint Pain/Swelling ☐ Joint Stiffness  
☐ Muscle Pain ☐ Back Pain

#### Gastrointestinal

☐ Denies All ☐ Diarrhea ☐ Ulcers  
☐ Heartburn ☐ Nausea/Vomiting ☐ Constipation

#### Skin

☐ Denies All ☐ Rashes/Sores ☐ Itching/Burning

#### Genitourinary

☐ Denies All ☐ Painful Urination ☐ Frequent Urination  
☐ Blood in Urine

#### Hematological

☐ Denies All ☐ Easy Bruising ☐ Bleeding Problem

#### Endocrine

☐ Denies All ☐ Heat Intolerance ☐ Cold Intolerance  
☐ Fatigue