pinnacle orthopaedics

PATIENT DEMOGRAPHICS FORM

Date: _____

INFORMATION PATIENT

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:	May we email medical information? ❑Yes ❑No	
Preferred Language: ❑ English ❑Spanish ❑ Other		
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	

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Home Phone:
Address (if different):		
Primary Insurance Name: _____		
Subscriber's name:	Policy #:	Copay: $
Subscriber DOB: Subscriber SSN:	Group #:	Group Name:
Patient's relationship to subscriber: : ❑ Self ❑Child ❑ Spouse ❑ Other		
Secondary Insurance Name: _____		
Subscriber's name:	Policy #:	Copay: $
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: _____

New Patient Information Form

Please darken bubbles completely

PATIENT INFORMATION	
Patient Name:	**Date:**
Height:	**Weight**
Referring Physician:	**Primary Care Physician:**

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

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

Is this work related? O Yes O No

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

What is your occupation? _____

Are you? O Right Handed O Left Handed **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)		

What are you being seen for today?

O Neck	O Right Hip	O Left Hip	O Right Thigh	O Left Thigh
O Mid Back	O Right Knee	O Left Knee	O Right Calf	O Left Calf
O Low back	O Right Ankle	O Left Ankle	O Right Foot	O Left Foot
O Ribs	O Right Shoulder	O Left Shoulder	O Right Elbow	O Left Elbow
	O Right Wrist	O Left Wrist	O Right Hand	O Left Hand

Pain Description:

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

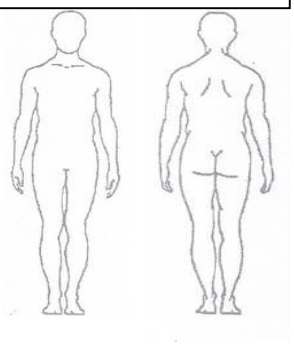
How would you describe your pain? O Sharp O Dull O Burning

Have you had physical/occupational therapy? O Yes O No

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

If yes, where and by whom? _____

Mark where your symptoms occur:



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

Patient Name _____ DOB _____

Are you taking any Medications for this problem?

O Narcotic (Vicodin, Codeine, etc.) O Anti-inflammatory (Advil, Motrin, etc.) O Muscle Relaxer (Flexeril, Soma, etc.)

O Steroids/Steroid Injections **(Please list other medications in detail above).**

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 this problem?

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

Medical History

O	Osteoporosis	O	High Blood Pressure	O	Diabetes	O	Arthritis
O	Poor Circulation	O	Degenerative Joint Disease	O	Heart Disease	O	Kidney Disease
O	Thyroid Disease	O	Degenerative Disc Disease	O	Anemia	O	Cancer
O	Epilepsy/Seizures	O	Congestive Heart Failure	O	Asthma	O	Emphysema/COPD
O	Pneumonia	O	Pulmonary Embolism	O	Heart Attack	O	DVT
O	Kidney Stones	O	Irregular Heart Beat	O	Stroke	O	IBS
O	Lupus	O	Rheumatoid Arthritis	O	Psoriasis		

Infectious Diseases

O	Tuberculosis	O	Lyme Disease	O	Hepatitis	O	MRSA

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

Social History

Do you smoke cigarettes?				O	Yes	O	No
How long have you smoked?	O	<1 year		O	1-10 years	O	10+ years
How many packs per day?	O	<1 pack		O	1-2 packs	O	3+ packs
Have you ever smoked cigarettes in the past?				O	Yes	O	No
Do you chew tobacco?				O	Yes	O	No
How many cans per week?	O	<1 can		O	1-2 cans	O	3+ cans
Do you drink alcohol	O	Yes		O	No	O	Socially
How many drinks per day?	O	<1 drink		O	2-3 drinks	O	4+ drinks
Do you exercise regularly?	O	No		O	2-3 times/ week	O	5+ times/week
Do you participate in sports/recreational activities?				O	Yes	O	No

If yes, what activities? _____

Family History

Mother	O	Cancer	O	Osteoporosis	O	Degenerative Joint Disease	O	Arthritis
Father	O	Cancer	O	Osteoporosis	O	Degenerative Joint Disease	O	Arthritis
Grandparents	O	Cancer	O	Osteoporosis	O	Degenerative Joint Disease	O	Arthritis
Siblings	O	Cancer	O	Osteoporosis	O	Degenerative Joint Disease	O	Arthritis

O None of the above O Unknown family history

Review of Systems: ***Are you experiencing any of these issues 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	Post Nasal Drip
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	Heartburn	O	Nausea/Vomiting	O	Constipation
O	Diarrhea	O	Ulcers	O	Gastric Reflux
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				

I hereby certify to the best of my knowledge that the information stated above is correct.

Patient/Guardian Signature _____ **DOB** _____ **Date** _____

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.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

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

Patient Name_____Account#_____

Signature of Patient or Responsible Party _____Date_____

Witnessed By _____Date_____

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

PATIENT ACKNOWLEDGMENT

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

PAYMENT RESPONSIBILITY

Payment for office 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 and diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered by my attending /covering physician.

Patient Name_____Account#_____

Signature of Patient or Responsible Party_____Date_____

Witnessed By_____Date_____

pinnacle orthopaedics

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)

I authorize Pinnacle Orthopaedics & Sports Medicine, LLC to use and/or disclose the protected health information (''PHI'') described below to:

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

Authorization for release of PHI covering the period of health care (select one)

☐ a. from (date) _____ - to (date)_____ OR
☐ b. all past, present and future periods.

I hereby authorize the release of PHI as follows (select one):

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

☐ b. my complete health record *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.

_____ Date: _____
Signature of Patient/Legal Guardian

Print patient name _____ Account number _____