



Patient Information Form

Chart# _____

Patient Name _____
LAST FIRST MIDDLE

Address _____
STREET, P.O. BOX AND OR SUITE #

CITY STATE ZIP

Home Phone # _____ Cell # _____ Work # _____

DOB _____ SSN # _____ Male _____ Female _____

Employer _____ Primary Ins. Carrier _____

Patient ID # _____ Policy # _____

Secondary Ins. Carrier _____

Patient ID # _____ Policy # _____

Please fill out the name of the primary cardholder of your insurance if it is different from the patient above.

Name _____
LAST FIRST MIDDLE

DOB _____ SSN # _____ Male _____ Female _____

Employer _____ Work # _____

PERMISSION TO GIVE MEDICAL INFORMATION

I, _____ hereby authorize the physician and staff of Powell Orthopedics, P.A. to contact in case of emergency, or to discuss any information about health, well being, or appointments concerning the patient, with myself or spouse or with the following person or people.

1. Name _____ Phone # _____

2. Name _____ Phone # _____

This is also an agreement to obtain medical services, assignment of benefits and authorization to release medical information. I authorize any holder of medical information about me to release it to Powell Orthopedics P.A. and or staff, any information needed. I also agree to an automated telephone system to call and remind me of a scheduled appointment and I acknowledge receiving a copy of the HIPAA notice of privacy practice today. Powell Orthopedics P.A. is also authorized to furnish to any insurance company, 3rd party payer, hospital or physician any and all information it may have concerning the patient, including, but not limited to, medical history, reports, consultations, prescriptions, treatment, x-rays, and all other requested information or documentation pertaining shall be considered as a valid and effective as the original.

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN Date _____



New Patient Information

Patient Name _____ Date _____
DOB _____ Age _____
Referring Physician _____ M ___ F ___ Dominant Hand: R L Both

PLEASE TELL US ABOUT YOUR ORTHOPEDIC PROBLEM:

When did it begin? _____ What caused it? _____
Previous Treatment? Yes No By whom? _____ When? _____

PAST SURGICAL HISTORY (please list)

1. _____ Dr. _____ Date _____
2. _____ Dr. _____ Date _____
3. _____ Dr. _____ Date _____
4. _____ Dr. _____ Date _____
5. _____ Dr. _____ Date _____
6. _____ Dr. _____ Date _____

PAST MEDICAL HISTORY: (circle all that apply)

- | | | |
|----------------|--------------------------|-------------------|
| Heart Disease | High Blood Pressure | Heart Attack |
| Stroke | Congestive Heart Failure | Bleeding Disorder |
| Blood Clots | Pulmonary Embolism | Lung Disease |
| Emphysema | Asthma | COPD |
| Kidney Disease | Liver Disease | Diabetes |
| | | Seizure Disorder |
- Other Health Problems: _____

MEDICINES (prescription and non-)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Hospitalizations (for what and when?): _____

ALLERGIES (medicine or other)

LEGAL

Problem due to an accident? Yes No Is litigation planned? Yes No
Auto accident? Yes No Attorney's name: _____
Do you have an attorney? Yes No Address/Phone: _____

PERSONAL AND FAMILY

Do you use tobacco? Yes No Amt. per day? _____ Since? _____
Do you use alcohol? Yes No Amt. per day? _____ Since? _____
Most physically demanding regular activity? _____ How often? _____
Occupation _____ Time at present employer? _____ Previous? _____
Marital Status: (circle) Single Married Divorced Widowed Living Status: (circle) Alone Spouse Children Parents Friend(s)
Family Health: (List health problems. If deceased, please note age of death.)
Father _____ Mother _____
Siblings _____ Children _____



Have you recently experienced any of the following – check if "yes".

HEENT

- Eye pain or glaucoma
- Require glasses
- Visual impairment not corrected by glasses
- Cataracts
- Trouble hearing
- Ringing of ears
- Repeated nose bleeds
- Trouble breathing through nose
- Difficulty swallowing
- Hoarseness
- Other difficulty speaking
- Lump in your neck
- Salivary gland problem

Cardiopulmonary

- Cough
- Coughing up phlegm
- Coughing up blood
- Pneumonia
- Collapsed lung
- Tuberculosis
- Asthma
- Hay fever
- Shortness of breath
- Shortness of breath walking
- Shortness of breath lying down
- Chest pain
- Heart attack
- Dizziness
- Loss of consciousness
- Rapid heart beat
- Irregular heart beat
- Rheumatic fever
- Blood clot in legs
- Phlebitis
- Pain in legs with walking
- Painful whitening of fingers

GI

- Abdominal pain
- Indigestion, heartburn
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Black stools

- Blood in stools
- Loss of appetite
- Ulcers
- Hiatal hernia
- Other hernia
- Jaundice
- Hepatitis
- Gallstones
- Colitis or enteritis
- Cirrhosis
- Pancreatitis
- Hemorrhoids

GU

- Urinary tract infection
- Burning with urination
- Dark or bloody urine
- Kidney stones
- Syphilis
- Gonorrhea
- Other venereal disease
- Trouble starting urination
- Bladder not emptying
- Decreased urinary stream

For Women

- Date of last menstrual period
- Are you pregnant
- Pain or other problems with intercourse
- Decreased sex drive
- Birth control pills/shots/implants

For Men

- Difficulty with erection
- Prostatitis
- Enlarged prostate
- Decreased sex drive
- Discharge from penis

Neuro

- Headaches
- Neck pain
- Back pain
- Weakness
- Numbness
- Unsteadiness

- Loss of coordination
- Tremor, shaking
- Confusion
- Memory loss
- Spells
- Seizures
- Stroke
- Traumatic brain injury

Other

- Weight loss/gain
- Joint stiffness
- Joint pain
- Joint swelling
- Poor sleeping
- Depression
- Anxiety
- Crying spells

Patient Initials

Date

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PLEASE READ: The patient is responsible for all fees, regardless of insurance coverage. PAYMENT IS REQUESTED AT THE TIME OF SERVICE.

A photocopy of this authorization shall have the same effect as the original.

PATIENT/GUARDIAN SIGNATURE _____

DATE _____

CHART# _____

**POWELL ORTHOPEDICS, P.A.
PAYMENT POLICY**

CO-PAYS & CO-INSURANCE: Your co-pay and or deductible/co-insurance (whichever applies) is due at the time of your office visit. Please understand that some co-pays only pay for the office visit and other services such as, X-rays, injections, etc. may apply to your deductible/co-insurance. We contact your insurance to get an explanation of benefits, however, the information we are given is not always accurate. You may want to call your insurance to confirm your benefits. After filing your claims sometimes we are informed by your insurance that you may owe more than what was collected at time of your visit. If this is the case we will send you a statement for the balance due.

SELF PAY: If you are not using insurance, full payment is due the same day as your visit.

LIABILITY OR 3RD PARTY INS: We do not file 3rd Party insurance. If your primary insurance will not pay due to an accident of any kind, you are responsible for the bill in full at time of service.

SCHOOL INSURANCE: We accept school insurance. We will not file school insurance unless we have the filled out and signed documents on the day of the visit and only up to 4 days after the visit. If we do not get these insurance documents from you in the allotted time, you will be responsible for filing it. Please understand, most school insurance does not pay the full amount of medical services and you will be responsible for the balance.

MEDICAID & AR KIDS PLANS OR INSURANCE REQUIRING A REFERRAL: Getting a referral is patient responsibility. If a primary care referral is required we must have the PCP referral on or before the day of your visit.

PAYMENT PLAN: We offer CARECREDIT, 6 MONTHS, 0 PERCENT PAYMENT PLANS for all balances over \$200.00. CareCredit can also be used for balances under \$200.00 but there is no discount and interest is charged by CareCredit. If you would like to qualify for a CareCredit card please call 1-800-365-8295 or contact them on line.

PAYMENT OF ANY BALANCE DUE / COLLECTIONS: If you receive a bill please pay as indicated on the statement to avoid collections. All billing for Dr. Powell and Physical Therapy is filed with your insurance by us and if you have a balance we send you a bill. Billing for durable medical equipment is filed and sent out by a 3rd party for us. Not paying your bill when due and not calling Powell Orthopedics, P.A. to discuss this matter can result in your account being sent to collections. Please understand we do not want to send our patients to collections but unfortunately we have to do this sometimes. If we send your account to collections we will never see you again as a patient and this may go against your credit rating.

MESSAGES LEFT ON YOUR PHONE REGARDING INSURANCE, BALANCE OR SCHEDULED APPOINTMENTS: Sometimes we need to call patients/responsible party and discuss insurance requests or balance due and we get a voice mail. We also have an automated message that may call to inform you of your appointment or we may need to reschedule your appointment. If this happens we would like your permission to leave you a voice message about this matter to inform you of what is going on. Please sign and print phone number so we may leave you a message.

Signature _____ DOB _____ Phone# _____

I HAVE READ, UNDERSTAND AND WILL ABIDE WITH THIS POLICY

Print full name: _____

Signature _____ SSN# _____ Date: _____