Physician Name: Stephen De Young, M.D.

PATIENT DEMOGRAPHIC INFORMATION SHEET

Last Name | **First Name** | **Middle** | **Social Security No.**

Date of Birth | **Age** | **Male or Female** *(Please circle one)* | **Marital Status: M S W D** *(Please circle one)*

Home Address | **City** | **State** | **Zip**

Home Phone | **Work Phone** | **Cell Phone**

Contact Preference: *(Please Check One)* **Home** **Work** **Cell** **Mail** | **Email Address**

Referred By: | **Phone #:**

EMERGENCY CONTACT INFORMATION

Name | **Phone No.** | **Alt. Phone** | **Relationship**

PATIENT EMPLOYER INFORMATION

Employer Name | **Phone** | **Fax**

Address | **City** | **State** | **Zip**

GUARANTOR / POLICY HOLDER INFORMATION

Last Name | **First Name** | **Middle** | **Social Security No.**

Date of Birth | **Patient's Relationship to Policy Holder** | **Home Phone** | **Cell Phone**

Employer Name | **Phone** | **Fax**

Employer Address | **City** | **State** | **Zip**

INSURANCE INFORMATION

Primary Insurance	**Name of Primary Insurance**	**ID/Policy Number**	**Group Number**	**Customer Service No.**
Secondary Insurance	**Name of Secondary Insurance**	**ID/Policy Number**	**Group Number**	**Customer Service No.**
Work Comp Insurance	**Name of WC Insurance**	**Claim #**	**Adjuster Name**	**Adjuster Phone No.**

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT RELEASE ME FROM MY PERSONAL RESPONSIBILITY FOR PAYMENT OF ALL CHARGES WITHIN 50 DAYS. **AUTHORIZATION TO RELEASE INFORMATION:** I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OF TREATMENT.

Signature: | **Date:**

BLACK INK ONLY

NAME: _____ **Page 1**
Date: _____ **(Use back of page If Necessary)**

PRESENT ILLNESS

Age: **Left or Right Handed:** **Race:** **Sex:**

Location of Pain or Injury:

Job Description: **Employer:** **Date of Injury:**

Describe Injury in Detail:

Describe Treatment in Detail as Best as Possible: (Describe in order of occurrence. Include location[emergency room, hospitalization in necessary, doctor's name, x-rays and results, medications given or prescribed, splints or casts and diagnosis given to you] Give approximate dates.

Description of Pain: (circle) Sharp, dull, aching, numbing, electrical or other

Is the Pain constant or does it come and go? (circle)

Does the Pain stay in one spot or does it shoot elsewhere? (i.e. arm, leg, other)
Describe:

What makes the Pain Worse? (circle) Rest, activity, movement, walking, standing, running, sitting, driving car, going up and down stairs, coughing, sneezing, bowel movement, hot, cold, change of weather or seasons, morning, afternoon, day, night, bending over, lifting, medications, other

What makes the Pain better? List (see above examples)

If the problem is related to a Joint, circle the following which pertain: Swelling, bruising, heat, redness, clicking, popping, grinding, locking, giving way, instability, coming out of joint

Describe any numbness, tingling, weakness, bowel or bladder disturbance:

Are you getting better, worse, or no change? (circle)

Describe any past problems with the Injured area:

Were there any additional Injuries as a result of the Accident?

PAST MEDICAL HISTORY

List Past Surgery (tonsils, appendix, etc.) Include dates and reasons for surgery if known.

1. **2.**
3. **4.**

List Medical Illnesses (diabetes, hypertension, cancer, asthma, TB, arthritis, seizures, heart, high cholesterol, lung disease, gout, etc.)
1. **2.**

List Allergies (medications, foods, x-ray dyes, etc.) Describe what happens.

List Past Trauma (broken bones, gunshot wounds, burns, etc)

List Family Related Illnesses (diabetes, hypertension, cancer, arthritis, TB, heart disease, inherited disorders, etc.)
1. **2.** **3.**

SOCIAL HISTORY:
Occupation: **Marital Status:** **Children:**

Smoke or Alcohol (how much per day): **Education:**

REVIEW OF SYSTEMS: **(Circle items which apply to you)**
General: Poor appetite, unexpected weight loss or gain, recent infection or cold, fever, chills, other

Skin: Rashes, other **Head: Frequent headaches, dizziness, other**

Eyes: Glasses, contacts, loss of vision, cataracts, color blindness, glaucoma, other

Ears: Loss of hearing, ringing, hearing aide, other **Nose: Chronic sinusitis, other**

Mouth: Dentures, partial plates, cavities, teeth missing, other

Cardiorespiratory: Heart races or pounds, chest pain, shortness of breath, prior heart attack, pneumonia, other

Gastrointestinal: Change in bowel habits, chronic diarrhea or constipation, tarry stools, blood in stools, hemorrhoids, ulcers, liver, gallbladder, bowel disease, other

Genitourinary: Bladder or Kidney infections, painful urination, blood in urine, difficulty controlling urination, prostatitis, penile/vaginal discharge or bleeding, other

Musculoskeletal: Joint pain or swelling, chronic neck or back pain, other

Neurological: Prior stroke or meningitis, numbness, tingling, weakness, other

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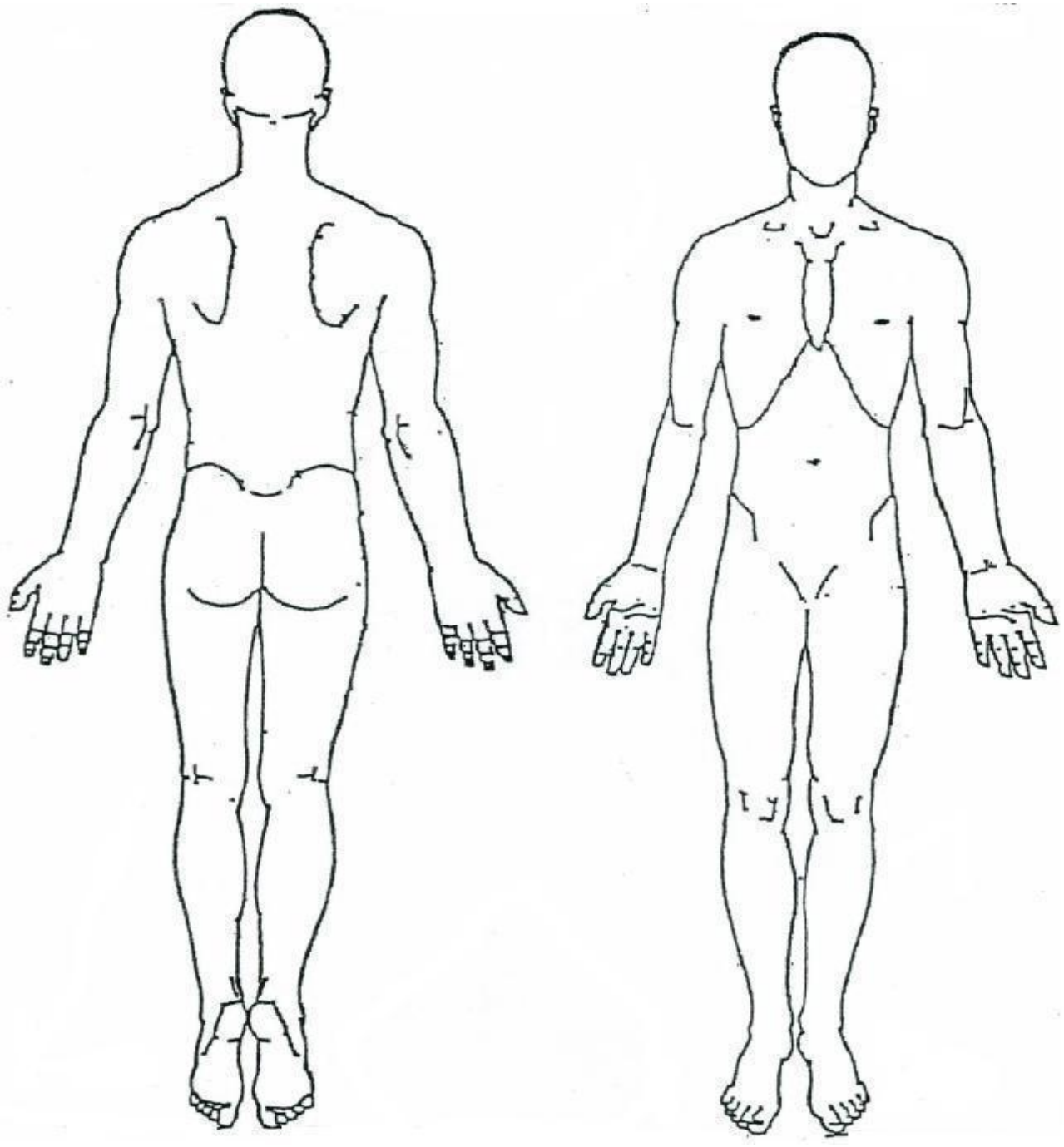
NAME: _____ **DATE:** _____

PAIN DRAWING

Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol. Mark areas of radiation. Include all affected areas.
Just to complete the picture please draw in your face.

Sharp,	----	Dull,	OOOO	Numbness	xxxx	Pins	////
Stabbing	----	Aching	OOOO		xxxx	and	////
Pain	----	Pain	OOOO		xxxx	Needles	////



Stephen De Young, M.D.

PLEASE COMPLETE ALL BLANKS BELOW. IF ANY INFORMATION IS INCORRECT, PLEASE CROSS IT OUT AND WRITE THE CORRECT INFORMATION. PLEASE SIGN AND DATE AT THE BOTTOM OF THE FORM.

PATIENT DEMOGRAPHIC INFORMATION

LAST NAME _____ **FIRST NAME** _____ **MIDDLE** _____ **PATIENT ID** _____

DATE OF BIRTH _____ **AGE** _____ **GENDER** _____ **SOCIAL SECURITY NO.** _____

HOME ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

HOME PHONE _____ **WORK PHONE** _____ **CELL PHONE** _____

MEDICATION ALLERGIES & PHARMACY INFORMATION

ALLERGIES: _____ **HEIGHT** _____ **WEIGHT** _____

PHARMACY NAME: _____ **PHONE #:** _____ **Fax #:** _____

LIST CURRENT MEDICATIONS YOU ARE TAKING

MEDICATION NAME AND STRENGTH

EXAMPLE: ASPIRIN 81 MG. ONCE A DAY

SMOKING STATUS

_____ Daily Smoker _____ Social Smoker

_____ Former Smoker _____ Never Smoked

MEDICAL HISTORY

_____ Hypertension _____ Diabetes

_____ Back Pain _____ Cholesterol

_____ Other _____

Patient Signature: _____ **DATE:** _____

SOUTHWEST ORTHOPEDIC GROUP, LLP

Review of Notice of Privacy Practices

Acknowledgement:

I acknowledge that I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Patient or Personal Representative Signature **Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____.

Financial Policy Statement

It is the policy of Southwest Orthopedic Group, L.L.P. to bill your insurance carrier as a courtesy to you; however, you are responsible for the entire bill. We require that arrangements for payment of your estimated share be made today. The insured/patient is responsible for any co-payments at the time service is rendered. If your insurance carrier does not remit payment within sixty (60) days, the balance will be due in full from you. If your insurance pays in excess of the balance of your account, we will refund the credit.

If any payment is made directly to you for services billed by Southwest Orthopedic Group, L.L.P., you recognize an obligation to promptly remit same to Southwest Orthopedic Group, L.L.P.

The above does not apply for those patients that are considered Workers' Compensation. However, be advised as a Compensation patient that you may be held responsible for your charges in the event that your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Southwest Orthopedic Group, L.L.P., I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.
The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

_____ _____

Responsible Party Print Name **Date**

_____

Responsible Party Signature