Physician Name: Michael G. Kaldis, M.D.

PATIENT DEMOGRAPHIC INFORMATION SHEET

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

Date of Birth | Age | Gender | 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: ______

Southwest Orthopedic Group, L.L.P.
Michael G. Kaldis, M.D.

Patient Medical History - General

Name ____Age ____ Sex _____ Height _______ Weight _______

Date of Evaluation: ___________________ Referred by ____

List of current medications currently taking (including vitamins), or attach a list:
____

Drug Allergies: ______No _____ Yes (If yes, please list): ____
____

Chief Complaint: (Please describe the reason for your visit today)_________________________________
____
____

Is the pain/problem constant or intermittent, and how long does it last (be specific)?
____

Date of Injury (if involved in accident) _________________________
Auto Accident _____ Yes _____ No On the Job _____ Yes _____ No

Name of Employer (if work related) ____
Occupational/Physical Requirements: ____
Attorney involved in case: ____

REVIEW OF SYSTEMS

Do you know or have you had problems related to the following systems: ***(Please check all that apply)***

GU
___ Trouble with urination
___ Frequent urination
___ Blood in urine

NEURO/PSYCH
____ Headache
____ Depression

ENT/PULMONARY
____ Sore throat
____ Cough
____ Trouble breathing
____ Chest pain

Other:
___ Fever ___°F
___ Chills

GI
____ Abdominal Pain
____ Nausea
____ Vomiting
____ Diarrhea
____ Black/bloody stool

SKIN
____ Skin rash

____ **None of the above**

PAST MEDICAL HISTORY: ***(Please check all that apply)***
____ High blood pressure
____ Heart disease
____ Diabetes (Insulin, oral, diet)
____ Peptic ulcer disease
____ Arthritis
____ Others ___________
____ Cancer

LIST ALL PAST SURGERIES, AS WELL AS CORRESPONDING DATES: ____________________________
____
____

SOCIAL HISTORY:
___ Smoker ____ packs per day
___ Drugs
___ Alcohol ____rarely ____ occasionally ____ heavily

FAMILY HISTORY:
____ Heart disease ____Diabetes ____ Cancer ____ Strokes

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 **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, LLP, 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, LLP, you recognize an obligation to promptly remit payment to Southwest Orthopedic Group, L.L.P.

The above does not apply to those patients that are considered Workers' Compensation. However, be advised as a Workers' 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, LLP, 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