Physician Name: Scott T. Orth, 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: ______

Scott T. Orth, M.D.

DATE: ___________________________ **NAME:** ____

COMPLAINTS OR PROBLEM: ____ **INDICATE: LEFT:** _____ **RIGHT:** _____

WHEN DID PROBLEM BEGIN? ____

____

____

REFERRED BY: ________________________________ **FAMILY DOCTOR'S NAME:** _______________________________

ARE YOU IN GENERAL GOOD HEALTH AT THIS TIME? YES _______ **NO** _______ **HEIGHT** _______ **WEIGHT** ______

EXPLAIN ALL OTHER MEDICAL PROBLEMS: ____

____

____

LIST ALL OPERATIONS OF ANY TYPE AND YEAR OF SURGERY: ____

____

____

HAVE YOU HAD PROBLEMS WITH ANESTHESIA, INFECTION, BLEEDING, OR OTHER SURGICAL COMPLICATIONS?
YES _____ **NO** _____ **EXPLAIN:** ____

____

HAVE YOU TAKEN MEDICINES FOR OR BEEN ON A DIET FOR: (CHECK YES OR NO)

	YES	NO		YES	NO		YES	NO
DIABETES	____	____	STOMACH ULCERS	____	____	NERVOUS CONDITION	____	____
HEART DISEASE	____	____	DIVERICULITIS	____	____	BLADDER DISEASE	____	____
KIDNEY DISEASE	____	____	SEIZURES	____	____	HIGH BLOOD PRESSURE	____	____
BLOOD THINNERS	____	____	ASTHMA/EMPHYSEMA	____	____	HORMONES/BIRTH CONTROL	____	____
ARTHRITIS	____	____	HEP/LIVER PROBLEMS	____	____	HIV/AIDS/RECURRENT INF.	____	____
THYROID DISEASE	____	____	GLAUCOMA	____	____	CANCER	____	____
CORTISONE	____	____	LUPUS	____	____	RHEUMATOID ARTHRITIS	____	____

LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING: ____

____

____

ARE YOU ALLERGIC TO ANY MEDICATION? YES ___ **NO** ___ **IF SO CIRCLE OR LIST:** PENICILLIN SULFA CODEINE
DEMEROL NOVOCAINE ____

HAVE YOU EVER BROKEN ANY BONES OR WORN A BRACE OR CAST? ____

IS THERE A HISTORY IN YOUR BLOOD RELATIVES OF (CIRCLE): HEART DISEASE CANCER ABNORMAL BLEEDING
CONGENITAL DISORDERS MUSCLE DISEASE LUPUS RHEUMATOID ARTHRITIS OTHER FAMILY DISORDERS _________

____

ARE YOUR PARENTS LIVING? MOTHER YES ____ NO _____ DIED AT AGE _____ OF ___________________________
FATHER YES ____ NO _____ DIED AT AGE _____ OF ___________________________

DO YOU USE/SMOKE TOBACCO? YES ____ NO ____ HOW MUCH? _____ (PACKS PER DAY) FOR _______ YEARS.

PLEASE ESTIMATE YOUR ALCOHOL CONSUMPTION (CIRCLE): DON'T USE LIGHT OCCASIONAL/SOCIAL
MODERATE HEAVY OVERUSE

ORTH KNEE SHEET

RIGHT LEFT BOTH

DATE: ___________________ **NAME:** __________________________________

AGE: _________ **WEIGHT:** ________ **lbs** **MALE** **FEMALE**

Do you have any heart problems? YES NO **Do you have stomach ulcers?** YES NO

Do you have a history of gout? YES NO **Do you have any other joint pain?** YES NO

PLEASE CIRCLE THE FOLLOWING:

NEW PATIENT / FOLLOW-UP NEW PROBLEM / WORKER'S COMP

WORKER'S COMP DATE OF INURY: ________/_______/_______

When and how did your pain begin? ____

____

Where is the pain in the knee? Outside / Inside / Front / Back / All Around

Do you have pain with the following: Please circle the appropriate answer:

Walking? YES NO **Nighttime Pain?** YES NO **Going up/down stairs?** YES NO

Catch? YES NO **Giving Away?** YES NO **Does the knee lock?** YES NO

Does the pain prevent you from normal daily activities? YES NO **Working?** YES NO

Is the pain sharp? YES NO **Pain with squatting/kneeling:** YES NO **Swelling?** YES NO

Is the swelling intermittent, constant or only after activities? ______________________________

Does your kneecap ever slip out of place? YES NO

Have you had knee surgery? YES NO **If Yes, Where/When?** __________________________

Have you had an knee MRI? YES NO **If Yes, Where/When?** __________________________

Have you had injections in the knee? YES NO **If Yes, When?** ____________________________

What medication(s) have you tried for the pain? Did it help? ________________________________

____

____

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