PRECISION BONE & JOINT

Harris S. Rose, MD

New Patient Demographics

Patient Name: _____ What should we call you? _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Mobile: _____ Work Tel: _____

Preferred Phone: ☐ Home ☐ Mobile ☐ Work Email: _____

Employer: _____ Employer Tel: _____

SSN: _____ Birthdate: _____

Primary Insurance Carrier: _____ Policy Number: _____

Secondary Insurance Carrier: _____ Policy Number: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

Complete below only if someone other than the patient is financially responsible for the patient's medical care.

Responsible Party: _____ Relationship: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Mobile: _____ Work Tel: _____

Preferred Phone: ☐ Home ☐ Mobile ☐ Work Email: _____

Employer: _____ Employer Tel: _____

SSN: _____ Birthdate: _____

Your Preferred Pharmacy: _____ Address: _____

Optional Information: Race/Ethnicity *(check all that apply)*

- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other
- ☐ American Indian or Alaska Native
- ☐ Hispanic or Latino
- ☐ White
- ☐ Decline to Provide

_____ _____

Signature of Patient or Parent of Minor Date

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FINANCIAL AND PRIVACY POLICIES

PAYMENT POLICIES

_____
INITIALS

- Co-pays, co-insurance, deductibles, and other fees are due at the time of your appointment.
- You may pay by credit card, cash, or check. Returned checks will result in a $25 fee.
- Missed appointments not canceled at least 24 hours in advance will result in a $50 fee.

INSURANCE POLICIES

_____
INITIALS

- Your insurance plan is a contract between you and your insurance provider. We will file claims on your behalf for those insurers with whom we are contracted and you agree to assign benefit payments to Precision Bone and Joint.
- If your insurance provider fails to make payments within a timely period (60 days), payment in full is expected from the patient or responsible party.
- Failure to respond to an insurer's request for information can result in claim denial. Should this occur, the account balance will become the immediate responsibility of the patient.
- Fracture treatment may be billed as a procedure and therefore subject to deductibles, co-insurance and a global period in the same manner as surgical treatment. Payment for treatment of a fracture is due at time of service.
- Estimated co-insurance and deductibles for surgical procedures are due when the procedure is scheduled.

MEDICAL RECORDS

_____
INITIALS

- You are entitled to copies of your medical record upon request. A fee of $25 for the first 20 pages and $.50 for each additional page will be assessed to cover document costs.
- A copy of x-ray images can be provided for a fee of $8.00 per image.
- Disability, FMLA, AFLAC and other forms will be completed in a reasonable time period (usually 2 business days.) A $25 fee will be assessed for completion of these documents.
- Our office may view your external prescription data as needed to provide medical care.

HEALTH INFORMATION PRIVACY PRACTICES

_____
INITIALS

I acknowledge that I have been provided with Precision Bone & Joint's Notice of Health Information Privacy Practices prior to any services being rendered. I consent to the use and disclosure of my medical information as set forth therein. Print copies are available in the office and the document can be viewed at www.pbjortho.com.

CONSENT FOR TREATMENT

_____
INITIALS

I authorize Precision Bone and Joint Physicians and other providers to evaluate and treat me or my family member for any illness or injury for which I seek medical care. I have read and understand the clinic polices and I further acknowledge that I accept the terms outlined in each of these policies.

_____ _____

Signature of Patient or Parent of Minor Date

PRECISION BONE & JOINT

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Medical History

Patient Name _____ Age _____

Referring Physician (if applicable) _____

Primary Physician _____

How did you hear about our office? _____

Chief Complaint/History of Present Illness

What problem are you here for today? _____

_____

What part of your body is affected? _____

☐ Right ☐ Left ☐ Both Which finger(s), if applicable? _____

What date did the injury occur or symptoms start? _____

How did the injury occur? _____

Where did the injury occur? _____

Is this work related? _____ If yes, did you file a Workers' Compensation claim? _____

Have you had any physical therapy for this issue? _____

What medications have you taken for pain? _____

Have you had any injections performed for this issue? _____

For this issue, have you had: ☐ X-rays ☐ MRI ☐ CT scan ☐ EMG/NCS ☐ Other _____

Where were the images/studies done? _____

Past Medical History

Please list any medical issues you have (e.g. diabetes, heart disease, high blood pressure, pregnancy):

_____

_____

Please list any major surgeries: _____

_____

Please list any drug allergies: _____

Please list all of the medicines you take: _____

_____

_____

_____

Height _____ **Weight** _____

Medical History (continued)

Family History

Do you have a family history of: ☐ Diabetes ☐ Rheumatoid Arthritis ☐ Heart Disease

Other _____

Social History

What is your occupation? _____ Are you currently working? _____

Do you use tobacco or smoke? ☐ Yes ☐ No If yes, how many packs per day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per day? _____

Are you: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Review of Systems	**Yes**	**No**		**Yes**	**No**
Fever/Chills/Nightsweats	☐	☐	Stroke	☐	☐
Unexplainable Weight Gain/Loss	☐	☐	Seizures	☐	☐
Joint Pain/Swelling/Stiffness	☐	☐	Visual Disturbances	☐	☐
Difficulty Breathing/Shortness of Breath	☐	☐	Difficulty with Balance	☐	☐
Chest Pain	☐	☐	Frequent Thirst or Frequent Urination	☐	☐
Stomach Pain/Ulcers	☐	☐	Easy/Excessive Bleeding or Bruising	☐	☐
Reflux/Heartburn	☐	☐	History of Blood Clot	☐	☐
Open Wounds or Rash	☐	☐	Reaction to Anesthesia	☐	☐

If you have answered yes to any of the above, please provide details: _____

_____

_____

_____

_____

_____ _____

Signature of Patient or Parent of Minor Date