

PORT CITY ORTHOPAEDICS, PLLC

INITIAL VISIT HISTORY FORM

Patient Name (Please Print): _____ Date: ____/____/____

Age: _____ Male Female Height ____ft ____in Weight: _____ Did you bring x-rays? YES NO

Who referred you to this office? Doctor (Name) _____ Attorney (Name) _____ Self-referral

What is the main reason for this visit? Pain Numbness Weakness Other _____ (Chief complaint)

Which body part(s) is/are involved? (location)						
<i>Neck</i> <input type="checkbox"/>	<i>Shoulder</i> <input type="checkbox"/> Right <input type="checkbox"/> Left	<i>Elbow</i> <input type="checkbox"/> Right <input type="checkbox"/> Left	<i>Hand</i> <input type="checkbox"/> Right <input type="checkbox"/> Left	<i>Pelvis</i> <input type="checkbox"/> Right <input type="checkbox"/> Left	<i>Knee</i> <input type="checkbox"/> Right <input type="checkbox"/> Left	<i>Foot</i> <input type="checkbox"/> Right <input type="checkbox"/> Left
<i>Back</i> <input type="checkbox"/> Mid <input type="checkbox"/> Lower	<i>Arm</i> <input type="checkbox"/> Right <input type="checkbox"/> Left	<i>Wrist</i> <input type="checkbox"/> Right <input type="checkbox"/> Left	<i>Finger</i> <input type="checkbox"/> Right <input type="checkbox"/> Left	<i>Hip</i> <input type="checkbox"/> Right <input type="checkbox"/> Left	<i>Ankle</i> <input type="checkbox"/> Right <input type="checkbox"/> Left	<i>Toe</i> <input type="checkbox"/> Right <input type="checkbox"/> Left

How long has this problem been present? _____ days weeks months

Check the box which best fits how your problem started. Then answer the one question below the box you checked. Use as much space to the right as needed.

NO INJURY (Onset was Gradual or Sudden)

Why do you think it started?

Answers to the ONE Question Checked at Left:

INJURY (NOT AUTO OR WORK)

Date _____. Where and how did it happen?

INJURY AT WORK (WORKER'S COMPENSATION)

Date _____. Where and how did it happen?

WORK RELATED BUT NO INJURY (WORKER'S COMP)

Date _____. How did your job cause this problem?

AUTO ACCIDENT (SELF PAY ACCT FOR LIABILITY)

Date _____. Where and how was your car hit?

PLEASE CHECK THE BOX THAT BEST DESCRIBES YOUR PROBLEM:

The pain is constant comes and goes (intermittent) in duration.

Severity of pain mild moderate severe extremely severe

What is the **quality** of the pain? sharp dull stabbing throbbing aching burning other _____

Are there **associated symptoms**? swelling numbness weakness fever weight loss

Since my problem started, it is: improving worsening unchanged

Does your pain wake you from sleep? Yes No

What makes your symptoms **worse**? activity exercise work other _____

What makes you feel **better**? rest heat ice elevation other _____

What medications have you taken or been prescribed for this problem? _____

Circle which treatments you have tried: Injection Brace Therapy Cane/Crutch

PORT CITY ORTHOPAEDICS, PLLC

INITIAL VISIT HISTORY FORM

Patient Name: _____ Date: _____

Please circle "Y" below if you have problems with these medical conditions and "N" if you do not have problems:

Skin/Breast:

- Y N Rash or problems with itching
- Y N Varicose veins
- Y N Breast lump

Endocrine:

- Y N Diabetes or high blood sugar
- Y N Do you take insulin?

Psychiatric:

- Y N Memory loss or confusion
- Y N Feelings of nervousness
- Y N Feelings of depression
- Y N Trouble sleeping

Ears/Eyes/Nose/Mouth /Throat:

- Y N Blurred or double vision
- Y N Eyes diseases
- Y N Hearing loss or ringing
- Y N Earaches or ear drainage
- Y N Sinus problems or "runny nose"
- Y N Nose bleeds
- Y N Loose or chipped teeth
- Y N Dentures or bridge
- Y N Problems opening mouth wide
- Y N Sore throat or change in voice
- Y N Swollen glands in your neck

Intestines and Kidneys:

- Y N Frequent, burning or painful urination
- Y N Blood in urine
- Y N Urinary incontinence or dribbling
- Y N Kidney stones
- Y N Kidney or liver disease
- Y N Males: Testicle pain
- Y N Males: Prostate problems
- Y N Females: Currently pregnant
- Y N Females: # of Pregnancies _____
- Y N Change in bowel movements
- Y N Nausea or vomiting
- Y N Frequent diarrhea
- Y N Rectal bleeding or blood in your bowel movements
- Y N Frequent abdominal pain or heartburn

Social:

- Y N Drink alcoholic beverages
If Yes, # drinks/day _____
- Y N Use any recreational drugs?
If Yes, type(s) _____
- Y N Smoke
If Yes, # packs/day _____

Lungs:

- Y N Breathing problems or asthma
- Y N Breathing problems during sleep
- Y N Tuberculosis or emphysema

Anesthesia History:

- Y N Any anesthesia problems other than nausea and vomiting?
- Y N Difficulty opening your mouth?
- Y N Family history of malignant hypertension?
- Y N History of prolonged weakness after anesthesia?

Cardiac (Heart and Blood Vessels):

- Y N Chest pain or angina pectoris
- Y N Heart disease or heart trouble
- Y N Recent chest pressure or tightness
- Y N Shortness of breath on exertion
- Y N Shortness of breath lying flat
- Y N High blood pressure
- Y N Recent heart palpitations
- Y N Swelling of the feet, ankles, or hands
- Y N Bleeding disorder
- Y N Take a blood thinner, e.g. Coumadin

Musculoskeletal:

- Y N Arthritis
- Y N Osteoporosis
- Y N Major fractures

Neurological (Nerves):

- Y N Frequent, recurring headaches
- Y N Dizziness
- Y N Numbness or tingling sensations
- Y N Convulsions, seizures or tremors
- Y N Any kind of head injury
- Y N Stroke or "mini stroke"

Medications Dose How Often?

Family History (Circle "Y" for all that apply)

- | | | |
|-----------------------|-----------------|-------------------|
| Y N Diabetes | Y N Cancer | Y N Hypertension |
| Y N Bleeding Tendency | Y N Sickle Cell | Y N Heart Disease |

Past Surgeries: Type Date Problems?

		Y N
		Y N
		Y N

Allergies: _____

Recent Procedures/Tests When? Where?

Other Medical Problems:

Height: _____ Weight: _____ Allergies: _____

Other Pertinent Information:

I certify that this information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ **Date:** _____

PORT CITY ORTHOPAEDICS, PLLC
PATIENT INFORMATION

Patient's Name: _____

Date: ___/___/___

Last

First

MI

Personal Information

Address: _____

City, State, Zip: _____

Home Phone: (____) _____

Cell Phone: (____) _____

E-mail Address: _____

Select a password to access your medical chart

SSN: _____

Relationship to Responsible Party: _____

Birth Date: _____ Male Female

Language Spoken (primary): _____

Married Single Divorced Separated Widowed

Primary Care Doctor: _____

Referring Doctor: _____

Secondary Insurance

Carrier Name: _____

Policy Holder's Name: _____

Policy Holder's Employer: _____

Patient Rel. to Policy Holder: Self Dependent
 Spouse Child Other: _____

Policy Holder Sex: Male Female

Policy Holder Date of Birth: _____

Spouse Information

Name: _____

Employer: _____

Date of Birth: _____

SSN: _____

Responsible Party Information

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: (____) _____

Work Phone: (____) _____

Employer: _____

SSN: _____ DOB: _____

Relationship to patient: _____

Employment

Full-Time (FT) Part-Time (PT) Unemployed
 Retired Student FT Student PT

Employer: _____

Employer address: _____

City, State, Zip: _____

Employer Phone #: _____

Primary Insurance

Carrier Name: _____

Policy Holder's Name: _____

Policy Holder's Employer: _____

Patient Rel. to Policy Holder: Self Dependent
 Spouse Child Other: _____

Policy Holder Sex: Male Female

Policy Holder Date of Birth: _____

Please list persons whom you wish to be able to access your medical information. These persons will need to know the **password** you selected for your account to provide and receive medical information for you.

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

PORT CITY ORTHOPAEDICS, PLLC
INSURANCE CARRIER & FINANCIAL POLICIES

INSURANCE CARRIER POLICY

We are happy to file your health insurance claims for you. To do this, you must provide us with complete and accurate insurance information. We require the original insurance card(s) and government issued photo identification to be presented at the initial visit. If your insurance information/coverage changes, you are responsible for updating this information with our office. We cannot be responsible for errors or omissions in the information you provide us, and insurance denials due for these reasons will result in the insurance balance moving to patient responsibility.

If you wish to file your own claims, or wish to file to an insurance other than health insurance (disability, auto insurance, etc), we are happy provide you with the required information so that you may file a claim with your insurance company. Under these circumstances, your account will be set up as a self-pay account.

FINANCIAL POLICY

Your clear understanding of our financial policy is important to our professional relationship. We are committed to providing you with the best possible care. We are open to discussing our professional fees with you at any time. Please ask if you have any questions.

Payment is due at the time services are rendered. For accounts for which we are filing to health insurance, this includes any Copay(s), Coinsurance, and/or Deductibles as outlined by your insurance carrier. For surgeries, we require this amount be paid in full prior to the date of surgery. We accept cash, debit cards, checks, Visa, MasterCard and American Express.

There is a \$25.00 fee for all returned checks. Balances older than 30 days are subject to additional service charges at 16% interest per year. If your account must be turned over to a collections agency, it will incur a collections charge equal to 28% of your outstanding balance. Charges may also be made for no-show appointments and appointments cancelled without 24 hour prior notice.

We realize that temporary financial problems arise. If you experience or are experiencing such a problem, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our financial and insurance policies. If you have any questions about the above information, do not hesitate to ask us. We are here to assist you. By signing this form you acknowledge that you have read the above policies in full and have had the opportunity to ask and have had answered any questions.

Signature: _____ Date: _____

Name (please Print): _____ Relationship to patient: _____

PORT CITY ORTHOPAEDICS, PLLC

CONSENT & AUTHORIZATION / HIPAA CONSENT

CONSENT AND AUTHORIZATION

I certify that the information provided is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Consent for Treatment: I hereby authorize the performance of any medical or surgical treatment that may be advised and recommended by my attending physician at Port City Orthopaedics, PLLC. Furthermore, I request the use of any facilities and services of Port City Orthopaedics, PLLC that may be regarded as necessary or beneficial in the performance of said treatment.

Authorizations: I hereby authorize Port City Orthopaedics, PLLC to release any information acquired in the course of my examination and/or treatment to the listed referring physician and to all physicians treating me. I give Port City Orthopaedics, PLLC permission to obtain any medical information needed from other sources in the course of my treatment or examination. I also authorize Port City Orthopaedics, PLLC to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the doctor all payments for medical services rendered to my dependents or me. I understand that this authorization will remain in effect for as long as my dependent or I remain a patient. I understand that I am financially responsible to Port City Orthopaedics, PLLC for charges not covered by this assignment. It is agreed that in the event the services of an attorney or collection agency are required to collect any outstanding balance owed to Port City Orthopaedics, PLLC, the cost of reasonable attorney's fees, collection fees and/or service fees will be added to the outstanding balance. I understand that even though I may have some type of insurance coverage, I am responsible for payment of services when they are rendered.

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. If we change our Notice, you may obtain a revised copy by contacting the office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Port City Orthopaedics, PLLC provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The Practice has a Notice of Privacy Practices and that you have the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- You have the right to restrict the use of the patient's information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent.

I have read the above Consent and Authorization and HIPAA Patient Consent form statements. My signature below indicates my understanding of and agreement to abide with the above.

Name (please print) _____ Signature: _____

Relationship to patient (if other than patient): _____ Date: _____

