

MIDDLE TN ORTHOPAEDICS, P.C.

PATIENT INFORMATION:

Date: \_\_\_\_\_

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Primary Care Dr or Family MD \_\_\_\_\_ Phone \_\_\_\_\_

Referred by: \_\_\_\_\_ Phone \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Widow(er) \_\_\_\_\_ Legally Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Partner \_\_\_\_\_

Social Security: \_\_\_\_\_ Driver's Lic: \_\_\_\_\_ State: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_

Your E-mail address: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Emergency Contact

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse Information

Name: \_\_\_\_\_

Spouse Date of Birth: \_\_\_\_\_ Spouse Social Sec #: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Primary Insurance Company \_\_\_\_\_

Policy Holder \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_

Policy Holder \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_ SS# \_\_\_\_\_

\*\*\*\*\*IF THE PATIENT IS A MINOR: Fill in the rest of the page:

Father: \_\_\_\_\_ Date Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Father's Social Security # \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Mother: \_\_\_\_\_ Date Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mother's Social Security # \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_



Name: \_\_\_\_\_ Date: \_\_\_\_\_

**FAMILY HISTORY--Does anyone in your family have a history of a major medical illness?**

***Please list any illness***		
Father	Alive	Deceased at Age _____
Mother	Alive	Deceased at Age _____
Grandfather	Alive	Deceased at Age _____
Grandmother	Alive	Deceased at Age _____
Siblings-How many Brothers		Sisters
Oldest Brother	Alive	Deceased at Age _____
Other Brother	Alive	Deceased at Age _____
Other Brother	Alive	Deceased at Age _____
Other Brother	Alive	Deceased at Age _____
Oldest Sister	Alive	Deceased at Age _____
Other Sister	Alive	Deceased at Age _____
Other Sister	Alive	Deceased at Age _____
Other Sister	Alive	Deceased at Age _____

Do you have any children? NO \_\_\_ Yes \_\_\_ #Sons \_\_\_ # Daughters \_\_\_

**Please list any illnesses/conditions and/or age deceased/cause**

Oldest child	Alive
2nd child	Alive
3rd child	Alive
4th child	Alive
5th child	Alive
6th child	Alive
7th child	Alive
8th child	Alive

**SOCIAL HISTORY**

Student Yes \_\_\_ No \_\_\_ Disabled: No \_\_\_ Yes \_\_\_ Retired: No \_\_\_ Yes \_\_\_

Occupation: \_\_\_\_\_ Religion: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Do you live alone? Yes \_\_\_ No with \_\_\_\_\_

Own home No \_\_\_ Yes \_\_\_

Do you drive? NO \_\_\_ Yes-Car \_\_\_ Truck \_\_\_ Automatic \_\_\_ Manual \_\_\_ Power Steering \_\_\_

Do you exercises: No \_\_\_ Yes \_\_\_ How often and what kind \_\_\_\_\_

Smoke: NO \_\_\_ Never \_\_\_ Quit \_\_\_ Yes \_\_\_ -How many packs a day \_\_\_\_\_ For how many years \_\_\_\_\_

Drug Abuse: No \_\_\_ Yes \_\_\_ -List details \_\_\_\_\_

Alcohol Use: No \_\_\_ Yes \_\_\_ Rarely \_\_\_ Occasionally \_\_\_ Socially \_\_\_ Daily \_\_\_ Quantity \_\_\_\_\_

Use assistive Devices: No \_\_\_ Cane \_\_\_ Walker \_\_\_ Crutches \_\_\_ Wheelchair \_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Any changes in the last 6 months \_\_\_\_\_

Middle TN Orthopaedics, P.C.  
353 New Shackle Island, #226B  
Hendersonville, TN 37075

Robert P Fogolin MD  
615-264-2600 phone  
615-264-1160 fax

**AUTHORIZATION AND AGREEMENT... READ CAREFULLY BEFORE SIGNING:**

As the patient or responsible party, I hereby consent to treatment.

**PAYMENT IS EXPECTED AT THE TIME OF VISIT**-If you do not have insurance or it cannot be verified, you will be asked for payment at each visit. Any patient's balance older than 90 days may be turned over to a billing and/or collection company. I understand I will be responsible for any interest billed or collection/legal fees which is presently 33.33%.

**MISSED APPOINTMENTS:** There is a fee for missed appointments. We require a 24 hours notice for any cancellation of an appointment. The first missed appointment without notice is noted in your chart. Upon your second missed appointment you will be charged a \$40.00 fee. This must be paid in full before another appointment can be scheduled. If you do have insurance, you will be asked for payment of **DEDUCTIBLES, COPAYS** or any **NON-COVERED SUPPLIES** at the time of each visit. **YOU ARE RESPONSIBLE FOR OBTAINING ANY NECESSARY REFERRALS FROM YOUR HEALTH INSURANCE COMPANY FOR YOUR OFFICE VISIT PRIOR TO YOUR** In order for us to file your insurance we must have a copy of all your insurance cards. **I UNDERSTAND THAT IF I DO NOT PRESENT ALL MY INSURANCE CARDS AT THE TIME OF SERVICE, MY CLAIMS WILL NOT BE FILED WITH THE INSURANCE COMPANY AND I AM RESPONSIBLE FOR PAYING THE COMPLETE CHARGES.**

I understand you will file my charges with my insurance company, however, I am responsible for any and all non-contractual amounts above the usual and customary charges for any non-covered services, and for any charges I did not obtain the necessary pre-certification my insurance company may require.

I authorize you to obtain or release any medical information, electronically or by written request, necessary to treat me for my medical complaints. Below is the list of individuals who you may discuss any medical, financial or appointment information with. If the person is not listed, we will not even be able to confirm that you are a patient of our practice. List "anyone" if you are unsure of whom you may have call on your behalf. This will only be changed by written request.

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_

**INSURANCE: SIGNATURE ON FILE**

I authorize the release of any medical information necessary to process the claim(s). I request payment of Medicare benefits or any other insurance companies to Middle TN Orthopaedics, P.C. on behalf of Robert P. Fogolin, M.D.

\*\*\*\*\* Responsible party name Printed: \_\_\_\_\_

\*\*\*\*\* Authorized responsible party Signature: \_\_\_\_\_

Date Authorized: \_\_\_\_\_

**Disability forms:** Please leave any disability forms with the receptionist including the \$10.00 fee. Make sure you have obtained an off-work excuse from Dr. Fogolin or these forms will not be completed. The billing office will have them completed within 7 working days. \_\_\_\_\_ **INITIAL**

**Request for your medical records:** A request may be made in writing for a copy of your medical records. There is a \$20.00 fee for these records. If you need them faxed to another physician, if you provide us with that fax number in your written request, we will not charge you. \_\_\_\_\_ **INITIAL**

**\*\*\*Everyone must read and accept the above agreements before treatment will be rendered.**

HIPAA Notice of Privacy Practices Authorization

One requirement of HIPAA is to have a signed authorization in your record instructing us as to whom we may provide any PHI (private health information).

Names, phone number and relationship to you, of whom we may provide information:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

\_\_\_ May we leave a message for you at work?

\_\_\_ May we leave a message on your answering machine?

\_\_\_ May we leave a message on your voice mail?

\_\_\_ May we leave a message with the emergency contact you have provided us?

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Privacy Officer at 615-264-2600.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Have you recently experienced:**

**Patient Name:** \_\_\_\_\_

**Constitutional**

- Fever  Yes  No
- Fatigue  Yes  No
- Weight loss (significant)  Yes  No
- Weight gain (significant)  Yes  No
- Insomnia  Yes  No
- Weakness  Yes  No

**Musculoskeletal-List body part affected:**

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- Joint stiffness  Yes  No
  - Joint pain  Yes  No
  - Joint swelling  Yes  No

**ENT**

- Cold  Yes  No
- Hearing loss  Yes  No
- Sore throat  Yes  No
- Ringing in ears  Yes  No
- Headache  Yes  No
- Wears dentures  Yes  No

**Ophthalmology**

- Blurring of vision  Yes  No
- Vision loss  Yes  No
- Wears contacts  Yes  No
- Wears glasses  Yes  No

**Respiratory**

- Asthma  Yes  No
- Shortness of breath  Yes  No
- Chest pain  Yes  No
- Cough  Yes  No
- COPD  Yes  No

**Cardiology**

- Heart Attack (MI)  Yes  No
- Palpitations  Yes  No
- Coronary Artery Disease  Yes  No
- Arrhythmia  Yes  No
- Hypertension  Yes  No

**Gastroenterology**

- Gastric Reflux  Yes  No
- Nausea  Yes  No
- Abdominal pain  Yes  No
- Blood in stool  Yes  No
- Hiatal Hernia  Yes  No
- Peptic ulcer disease  Yes  No

**Dermatology**

- Psoriasis  Yes  No
- Skin cancer  Yes  No

**Neurology**

- Migraines  Yes  No
- Seizures  Yes  No
- Tingling/ numb arms/legs  Yes  No
- Restless leg symptoms  Yes  No
- Stroke  Yes  No
- Parkinson's  Yes  No

**Urology**

- Recurrent UTI  Yes  No
- Prostate problems  Yes  No
- Kidney failure  Yes  No
- Urinary incontinence  Yes  No

**Endocrinology**

- High Cholesterol  Yes  No
- Thyroid Disorder  Yes  No
- Diabetes (type?) \_\_\_\_\_  Yes  No

**Hematology/Lymph**

- Anemia  Yes  No
- Clotting Problem  Yes  No
- Bleeding Disorder  Yes  No
- Cancer (type?) \_\_\_\_\_  Yes  No

**Psychology**

- Depression  Yes  No
- Anxiety  Yes  No
- Suicidal ideation  Yes  No
- Claustrophobic  Yes  No
- Bipolar Disorder  Yes  No
- Schizophrenia  Yes  No

**Rheumatology**

- Gout  Yes  No
- Lupus  Yes  No
- Rheumatoid Arthritis  Yes  No

**Other Medical Conditions:**

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