

Nashville Orthopaedic Specialists, PC

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www.orthonashville.com

ARE YOU DIABETIC? Y ___ N ___

Patient Name _____ Date: _____

LAST: _____ FIRST: _____ MIDDLE: _____

SOCIAL SECURITY# _____ DOB: _____ AGE: _____ SEX: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME# _____ CELL# _____ WORK# _____

E-Mail Address: _____

EMPLOYER: _____ OCCUPATION: _____

SPOUSE'S NAME: _____ EMPLOYER: _____ PHONE: _____

IN CASE OF EMERGENCY PLEASE CONTACT: **(SOMEONE THAT DOES NOT LIVE WITH YOU)**

NAME: _____ PHONE: _____ RELATIONSHIP: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

PRIMARY INSURANCE: _____	ID #: _____
NAME OF POLICY HOLDER: _____	DOB: _____
SOCIAL SECURITY # _____	POLICY HOLDER'S RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT

SECONDARY INSURANCE: _____	ID #: _____
NAME OF POLICY HOLDER: _____	DOB: _____
SOCIAL SECURITY # _____	POLICY HOLDER'S RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT

PHYSICIAN YOU ARE SEEING TODAY KIOSCHOS JOHNSON MCCLURE HOLMES



Patient name _____

Name you like to be called _____

Age _____ Date of Birth _____

Occupation/school _____ Referred by _____ Primary care physician _____

Drug and other allergies _____

Medications (name, dosage & frequency) 1. _____

2. _____ 3. _____

4. _____ 5. _____

6. _____ 7. _____

Surgeries (type and date) 1. _____

2. _____ 3. _____

4. _____ 5. _____

Have you ever had or are currently having?

General Health

- Current Fever, Current Chills, Recent Weight loss/appetite change, Cancer

ENT

- Deafness, Chronic Sinusitis, Ringing in Ears

Respiratory

- Asthma/wheezing, Emphysema/chronic bronchitis, Tuberculosis

- Shortness of breath after walking one city block, Sleep apnea

- Chronic Cough, Coughed up blood

Skin

- Rashes/lesions, Skin Cancer, Eczema/atopic dermatitis

Bones, Muscles, Joints

- Fractures, Severe Sprains, Chronic Pain, Swelling, Arthritis, Chronic Stiffness, Fibromyalgia, Osteoporosis

Comments on "Yes" answers

If any blood relative has had any of the following, please circle and indicate who (Mother, Father, Sister, Brother):

- Epilepsy, Arthritis, Stroke, Asthma, High blood pressure, Blood clots, Thyroid disease, Migraines, Heart attacks, Diabetes, High cholesterol, Cancer (types):

Eyes

- Double vision/blurring, Glaucoma, Cataracts, Glasses/contacts

Cardiovascular

- High blood pressure, Heart attack/coronary artery disease, Chest pain/Angina, Heart murmur, High cholesterol, Irregular heart beat/palpitations, Heart failure, Pacemaker

Bladder, Kidneys, Other Urologic

- Kidney failure/dialysis, Enlarged prostate, Prostate cancer, Frequent infections, Blood in urine, Other problems

Gynecologic (women)

- Ovarian, cervical, uterine cancer, Lack of menstrual periods, Irregular menstrual periods

Chance you are pregnant

Gastrointestinal

- Acid reflux/heartburn, Hepatitis, Cirrhosis/liver disease, Chronic Abdominal pain, Chronic Constipation, Chronic Diarrhea, Blood in stool, Vomited blood, Ulcers

Comments on "Yes" Answers

Neurologic

- Stroke, Numbness/tingling in arms legs, Seizures/Epilepsy, Balance problems/dizziness, Memory problems, Migraine headaches

Endocrine

- Diabetes, onset age _____, Thyroid problems

Blood Disorders

- Anemia/sickle cell disease, Bleeding disorder, Blood clots, HIV positive

Psychologic

- Depression, Anxiety/panic attacks

Allergic/Immunologic

- Rheumatoid arthritis, Lupus, Unexplained fever after surgery, Unusual reaction to anesthesia by you or family member

Comments on "Yes" Answers/Other Medical Problems

Social History

Do you smoke _____ packs/day _____ number of years _____

Do you average more than 2 alcoholic beverages per day _____

Do you use recreational or illegal drugs _____

Married/single (circle) _____

Number of children/ages _____

Patient or guardian sign & date

The above information is complete and accurate _____

Date _____

Reviewed by _____ MD _____ Date _____



Name _____ Date _____

Briefly describe your primary problem _____

What do you hope to accomplish today? _____

When did symptoms begin? _____ Is this an injury? _____ If yes, then briefly describe the details

What other physicians have you already seen for this problem? _____

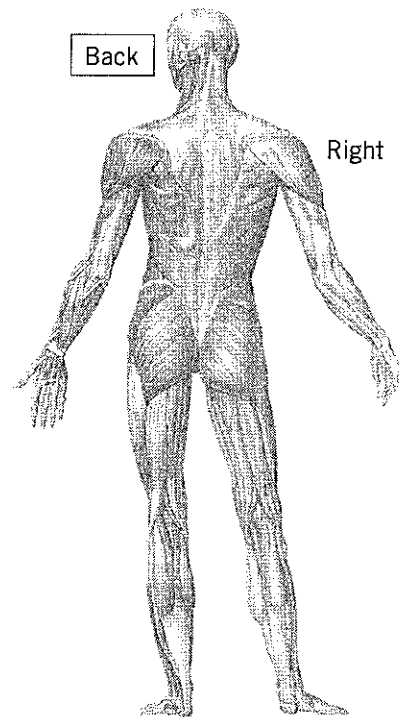
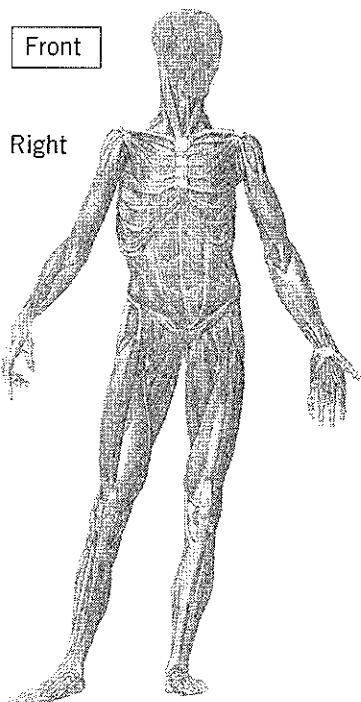
What tests (xrays, MRI, labs, etc) have already been done for this problem? _____

What treatments (medications, physical therapy, surgery, etc.) have you received for this problem? _____

What activities make your pain or symptoms worse? _____

What makes your pain or symptoms better? _____

**Please mark on the models
with an "X" the area of
your most pain or greatest
symptoms:**



FOR PHYSICIAN'S USE Notes: _____

Plan: MRI _____ Medication _____

PT _____ Other _____

Acknowledgment of Receipt of Privacy Notice (HIPAA)

I, _____, hereby acknowledge receipt of the notice of privacy practices given to me by Nashville Orthopaedic Specialists, PC.

Patient Signature: _____ Date: _____

Telephone/ Communication Permission

Where do you prefer to receive calls? **Please check all that apply**

- Home Phone # _____
- May leave message with detailed information Call back number only
- Work phone # _____ Ext. _____
- May leave message with detailed information Call back number only
- Mobile Phone # _____
- May leave message with detailed information Call back number only

I agree to allow _____
List any names that apply (i.e. spouse, children, significant other, ect.)
to speak with employees of Nashville Orthopaedic Specialists, PC on my behalf.

May we contact you via e-mail? _____

Patient Signature: _____ Date: _____

Nashville Orthopaedic Specialists, PC

Financial Policy

Thank you for choosing us as your health care provider. The following is our financial policy. We ask that you sign the bottom of this form indicating that you have read and understand these guidelines. If you have any questions, please consult with a member of our office staff.

Cash/Non-Insured Patients: An up-front payment of \$500 is due at check-in. If your charges exceed \$500 for the visit, you will be billed for the difference. If your charges are less than \$500, you will be promptly refunded the difference.

Insured Patients: Co-pays and deductibles are due at time of service, at check-in. For your convenience we accept cash, checks, MasterCard, Visa, and American Express.

As a rule, we try to verify all benefits prior to your appointment, but in some cases this is not possible. It is your ultimate responsibility to make sure we are a provider, what your benefits are, and that you have active insurance and have supplied us with that information, when applicable. In the event that your insurance claim is denied, you will be responsible for services rendered.

If your insurance plan requires a referral from your PCP, it is **your** responsibility to ensure that our office is in possession of the referral letter or number prior to your visit. If the referral is not made available to us by the time of your visit, you may choose to pay for the visit or reschedule your appointment.

From time to time, your insurance company may request further information from you before processing your claim. Failure to comply with this request in a timely manner may result in your claim being denied. In that event, you will be held responsible for the entire amount of the claim.

Return checks will be subject to a \$30 fee.

Delinquent accounts will be turned over to an outside collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In the event your account is turned over for collection, you will be responsible for all reasonable collection and court costs.

There will be a \$25 charge for forms completion by our physicians, due prior to forms completion.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Patient's Signature: _____ **Date:** _____

Assignment Of Benefits

I hereby guarantee payment of all charges for services rendered by Nashville Orthopaedic Specialists, PC. I hereby assign and direct to pay any and all benefits for medical services under this claim directly to Nashville Orthopaedic Specialists, PC. I hereby authorize the release of any medical information requested by the insurance companies with the above assignment.

Patient's Signature: _____ **Date:** _____

