Nashville Orthopaedic Specialists, PC

J Michael Kioschos, MD * * F Clarke Holmes, IV MD
www.orthonashville.com

Demographic Update Form

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: __________________________________
May we contact you via e-mail? _____Yes ____No

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: [ ] SELF [ ] SPOUSE [ ] PARENT

SECONDARY INSURANCE: _________________________ ID #: _______________________

NAME OF POLICY HOLDER: ________________________ DOB: ________________

SOCIAL SECURITY # ___________________
POLICY HOLDER'S RELATIONSHIP TO PATIENT: [ ] SELF [ ] SPOUSE [ ] PARENT

PHYSICIAN YOU ARE SEEING TODAY [ ] DR. KIOSCHOS [ ] DR. HOLMES

Updated 01/19/2011

NASHVILLE
Orthopaedic Specialists, PC

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 ☐ Yes ☐ No
- Current Chills ☐ Yes ☐ No
- RecentWeight loss/appetite change ☐ Yes ☐ No
- Cancer ☐ Yes ☐ No

ENT
- Deafness ☐ Yes ☐ No
- Chronic Sinusitis ☐ Yes ☐ No
- Ringing in Ears ☐ Yes ☐ No

Respiratory
- Asthma/wheezing ☐ Yes ☐ No
- Emphysema/chronic bronchitis ☐ Yes ☐ No
- Tuberculosis ☐ Yes ☐ No
- Shortness of breath after walking one city block ☐ Yes ☐ No
- Sleep apnea ☐ Yes ☐ No
- Chronic Cough ☐ Yes ☐ No
- Coughed up blood ☐ Yes ☐ No

Skin
- Rashes/lesions ☐ Yes ☐ No
- Skin Cancer ☐ Yes ☐ No
- Eczema/atopic dermatitis ☐ Yes ☐ No

Bones, Muscles, Joints
- Fractures ☐ Yes ☐ No
- Severe Sprains ☐ Yes ☐ No
- Chronic Pain ☐ Yes ☐ No
- Swelling ☐ Yes ☐ No
- Arthritis ☐ Yes ☐ No
- Chronic Stiffness ☐ Yes ☐ No
- Fibromyalgia ☐ Yes ☐ No
- Osteoporosis ☐ Yes ☐ No

Comments on "Yes" answers

____

____

____

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

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

____

____

Eyes
- Double vision/blurring ☐ Yes ☐ No
- Glaucoma ☐ Yes ☐ No
- Cataracts ☐ Yes ☐ No
- Glasses/contacts ☐ Yes ☐ No

Cardiovascular
- High blood pressure ☐ Yes ☐ No
- Heart attack/coronary artery disease ☐ Yes ☐ No
- Chest pain/Angina ☐ Yes ☐ No
- Heart murmur ☐ Yes ☐ No
- High cholesterol ☐ Yes ☐ No
- Irregular heart beat/palpitations ☐ Yes ☐ No
- Heart failure ☐ Yes ☐ No
- Pacemaker ☐ Yes ☐ No

Bladder, Kidneys, Other Urologic
- Kidney failure/dialysis ☐ Yes ☐ No
- Enlarged prostate ☐ Yes ☐ No
- Prostate cancer ☐ Yes ☐ No
- Frequent infections ☐ Yes ☐ No
- Blood in urine ☐ Yes ☐ No
- Other problems ☐ Yes ☐ No

Gynecologic (women)
- Ovarian, cervical, uterine cancer ☐ Yes ☐ No
- Lack of menstrual periods ☐ Yes ☐ No
- Irregular menstrual periods ☐ Yes ☐ No
- *Chance you are pregnant* ☐ Yes ☐ No

Gastrointestinal
- Acid reflux/heartburn ☐ Yes ☐ No
- Hepatitis ☐ Yes ☐ No
- Cirrhosis/liver disease ☐ Yes ☐ No
- Chronic Abdominal pain ☐ Yes ☐ No
- Chronic Constipation ☐ Yes ☐ No
- Chronic Diarrhea ☐ Yes ☐ No
- Blood in stool ☐ Yes ☐ No
- Vomited blood ☐ Yes ☐ No
- Ulcers ☐ Yes ☐ No

Comments on "Yes" Answers

____

____

Neurologic
- Stroke ☐ Yes ☐ No
- Numbness/tingling in arms,legs ☐ Yes ☐ No
- Seizures/Epilepsy ☐ Yes ☐ No
- Balance problems/dizziness ☐ Yes ☐ No
- Memory problems ☐ Yes ☐ No
- Migraine headaches ☐ Yes ☐ No

Endocrine
- Diabetes, onset age______ ☐ Yes ☐ No
- Thyroid problems ☐ Yes ☐ No

Blood Disorders
- Anemia/sickle cell disease ☐ Yes ☐ No
- Bleeding disorder ☐ Yes ☐ No
- Blood clots ☐ Yes ☐ No
- HIV positive ☐ Yes ☐ No

Psychologic
- Depression ☐ Yes ☐ No
- Anxiety/panic attacks ☐ Yes ☐ No

Allergic/Immunologic
- Rheumatoid arthritis ☐ Yes ☐ No
- Lupus ☐ Yes ☐ No
- Unexplained fever after surgery ☐ Yes ☐ No
- Unusual reaction to anesthesia by you or family member ☐ Yes ☐ No

Comments on "Yes" Answers/Other Medical Problems ____________________

____

____

Social History
- Do you smoke ☐ Yes ☐ No
  - packs/day_______ number of years________
- Do you average more than 2 alcoholic beverages per day ☐ Yes ☐ No
- Do you use recreational or illegal drugs ☐ Yes ☐ No

Married/single (circle)

Number of children/ages__________________

Patient or guardian sign & date

The above information is complete and accurate____________________

Date________________

Reviewed by ________________ MD ________________ Date

NASHVILLE
Orthopaedic Specialists, PC

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? ____________________________________

____

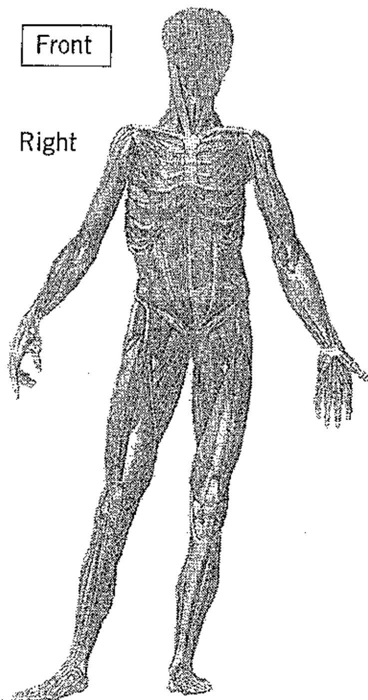
What makes your pain or symptoms better? ____

____

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

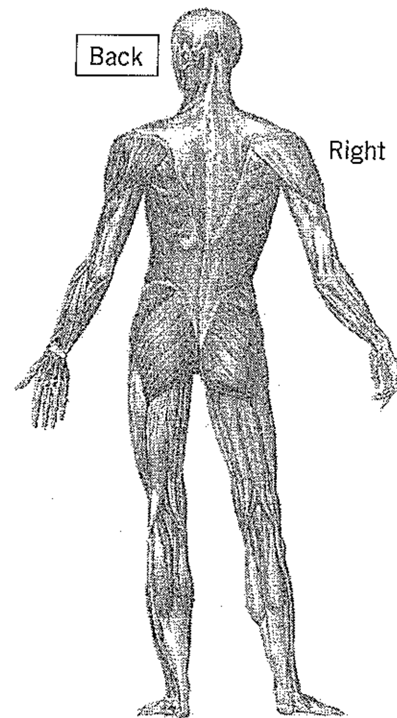
Front

Right



Back

Right



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 costs, including but not limited to attorney fees 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:** __________________

NASHVILLE
Orthopaedic Specialists, PC

As part of our on-going commitment to your health and well-being, Nashville Orthopaedic Specialists, PC (NOS) strictly adheres to the following policies regarding the dispensing of Narcotic and Pain Medicine.

****

At the discretion of the physician, Nashville Orthopaedic Specialists may prescribe narcotic medications, typically only for short-term use NOS physicians typically do not prescribe narcotics for chronic conditions or long-term use Patients should refer to their Primary Care Physician for any medication needs not related to their orthopedic condition

If you are a surgical patient, you will be prescribed appropriate pain medicine post-operatively. Dosages will be decreased as quickly as possible.

Please allow 24-48 hours for prescription refills. Please contact your pharmacy to request the medication refill They will fax to us a refill request. Our office will communicate to the pharmacy an approval or denial

Pain medications will not be refilled after normal office hours, on weekends or on holidays. Our office hours are Monday through Thursday 8:00AM - 4:30PM, and Friday 8:00AM – Noon.

Patients found to be receiving additional pain medication from other doctors or practitioners may have their pain medications from this office immediately discontinued, with no future prescriptions given from this office

Please provide us with your pharmacy information in the area below. This will be the pharmacy we will communicate with regarding any refill requests.

Pharmacy Name: ____________________________________
Pharmacy Address: ____________________________________
Pharmacy Phone Number: _________________________________

Medication Allergies: ____

Failure to complete all requested information will delay or even prevent you from receiving or refilling a prescription.

Tennessee has established a narcotic medicine abuse database to monitor people who are using large quantities of narcotic medications and/or are receiving pain medicine prescriptions from multiple doctors. Any abuse of above policy or abuse noted by the state of Tennessee will permanently halt any further prescriptions from Nashville Orthopaedic Specialists, PC

Printed Name	Signature	Date of Birth	Today's Date