

THE CENTER FOR ORTHOPAEDICS, INC.

1524 ATWOOD AVENUE • JOHNSTON, RHODE ISLAND 02919

DATE _____ NAME OF PATIENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ DATE OF BIRTH _____ AGE _____ M S W D

EMPLOYER _____ OCCUPATION _____

WORK PHONE _____ SOCIAL SECURITY NUMBER _____

INSURANCE:

BLUE CROSS MEDICARE UNHP. OTHER: _____

NAME OF SPOUSE, PARENT OR NEXT OF KIN _____

ADDRESS _____ PHONE _____ EMPLOYER _____

INSURANCE CARD HOLDER'S NAME _____

ADDRESS _____ SS# _____ DOB _____

REFERRING PHYSICIAN _____ PRIMARY CARE PHYSICIAN _____

REASON FOR VISIT (CHIEF COMPLAINT) _____

PAST MEDICAL HISTORY:

HEIGHT: _____ WEIGHT: _____ RIGHT HANDED LEFT HANDED

*CHECK THE IF YOU HAVE OR HAVE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> HEART DISEASE (TYPE _____) |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> DRUG ABUSE | <input type="checkbox"/> FIBROMYALGIA | <input type="checkbox"/> CANCER (TYPE _____) |
| <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> BLOOD CLOT IN LEG (PHLEBITIS) |
| <input type="checkbox"/> HIV POSITIVE | <input type="checkbox"/> LUNG DISEASE | <input type="checkbox"/> BLOOD CLOT IN LUNG (PULMONARY EMBOLUS) | |
| <input type="checkbox"/> ULCER (STOMACH OR DUODENAL) | <input type="checkbox"/> HIGH BLOOD PRESSURE | | |
| <input type="checkbox"/> PSYCHOLOGICAL DISORDER | <input type="checkbox"/> RHEUMATOID ARTHRITIS | | |

PAST SURGICAL HISTORY: (PLEASE LIST ANY OPERATIONS YOU HAVE HAD)

MEDICATIONS: (PLEASE LIST)

ALLERGIES TO MEDICATIONS/FOOD?

- YES TO WHAT? _____
 NO

FAMILY HISTORY

*PLEASE LIST THE HEALTH STATUS OR CAUSE OF DEATH AND AGE OF YOUR:

FATHER: _____

MOTHER: _____

BROTHER(S): _____

SISTER(S): _____

SOCIAL HISTORY:

DO YOU SMOKE? _____
 YES: HOW MUCH? _____ PER DAY _____ YEARS.
IF YOU HAVE QUIT, HOW LONG AGO? _____

NO

HOW OFTEN DO YOU DRINK ALCOHOL?

- NEVER 1-2 DRINKS A WEEK
 3-5 DRINKS A WEEK DAILY

CHILD IMMUNIZATIONS: YES NO

| |
|---|
| WORKERS COMP. <input type="checkbox"/> YES <input type="checkbox"/> NO |
| INSURANCE CARRIER _____ |
| ADDRESS _____ |
| PHONE _____ |
| DATE OF INJURY _____ |

| |
|---|
| AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ATTORNEY'S NAME _____ |
| ADDRESS _____ |
| PHONE _____ |
| DATE OF ACCIDENT _____ |

PATIENT RESPONSIBILITY

I understand that the office call fee, initial and follow up, is my responsibility if I have Blue Cross coverage. If I have other insurance coverage, I understand that if I provide an insurance form my charges will be filed for me and if there is any remaining balance it will be my responsibility. If I have no insurance coverage, I understand that all charges are my responsibility.

I understand that if I do not pay any amount which is owed you within thirty (30) days after receipt of your statement for services rendered, then I will be in default of this agreement, and I will pay the reasonable cost to collect the balance owed to you, including reasonable attorneys fees, to the extent permitted by law.

I request that payment of authorized Medicare benefits be made to me or on my behalf to THE CENTER FOR ORTHOPAEDICS, INC. for any services furnished me by that physician. I authorized THE CENTER FOR ORTHOPAEDICS, INC. to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I hereby request the payment of medical benefit to the doctor or party who accepts assignment. This authorizes the holder to release any information related to claims to my insurance companies.

Date: _____ Patient's Signature: _____

Signature of Parent or Guardian: _____

HIPPA AWARENESS:

I am aware that THE CENTER FOR ORTHOPAEDICS, INC. is in Compliance with HIPPA rules and regulations and this privacy act has been explained to me.

Patient's Signature: _____