TRI-COUNTY ORTHOPEDICS

World-Class Team. Hometown Choice.

Last Name	First Name	MI	Age	Date of Birth	Today's Date

Contact Phone #	Occupation:	Did a Physician refer you today? Name of referring physician: _____

Primary Care Physician Name, Address and Phone #:	Pharmacy Name, Street address, City and State:
Cardiologist: (if applicable) Address & Phone Number	Are you: (please check one) ◇ A New Patient To The Practice ◇ An Established Patient To The Practice

MEDICATION:

Are you currently taking any medications? ◇ YES ◇ NO (If yes, please list below):

MEDICATION NAME	DOSAGE	DIRECTIONS		MEDICATION NAME	DOSAGE	DIRECTIONS

Are you currently taking any Blood Thinners? ◇ YES ◇ NO (If yes, check all that apply):

◇ Aspirin ◇ Lovenox (Enoxaparin) ◇ Coumadin (Warfarin) ◇ Plavix (Clopidogrel) ◇ Xarelto (Rvaroxaban) ◇ Eliquis (Apixaban) ◇ Pradaxa (Dabigatran) ◇ Other: _____

Are you currently taking an Immunosuppressant? ◇ YES ◇ NO (If yes, check all that apply):

◇ Prednisone ◇ Remicaid ◇ CellCept ◇ Humira ◇ Other: _____

ALLERGIES:

Are you allergic to any of the following MEDICATIONS?				**Are you allergic to any of the following NON - MEDICATIONS?**		
◇ No Medication Allergies	**YES**	**NO**			**YES**	**NO**
Codeine	◇	◇		Latex	◇	◇
Penicillin	◇	◇		Nickels / Metals	◇	◇
Sulfa	◇	◇		Cinnamon	◇	◇
Other: _____	◇	◇		Poultry	◇	◇
Other: _____	◇	◇		Shell Fish	◇	◇
Other: _____	◇	◇		Seasonal	◇	◇
				Other: _____	◇	◇

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MEDICAL HISTORY: Please CHECK any conditions that you have had in the past or have currently

Height	
Weight	

◇ **No Significant Medical History To Report**

Cardiovascular
- ◇ High Blood Pressure
- ◇ High Cholesterol
- ◇ History of Blood Clot
- ◇ Atrial Fibrillation

Heart Disease:
- ◇ Cardiac Stent
- ◇ Bypass Surgery
- ◇ Pacemaker
- ◇ Heart Murmur
- ◇ Mitral Valve Prolapse
- ◇ Congestive Heart Failure
- ◇ Stroke
- ◇ Anemia
- ◇ Heart Attack

Respiratory
- ◇ Asthma
- ◇ COPD
- ◇ Sleep Apnea

OB/GYN

Possible Pregnancy? ◇ Yes ◇ No

Last Menstrual Period: _____

Menopause? ◇ Yes ◇ No

Orthopedic
- ◇ Osteoarthritis
- ◇ Gout
- ◇ Osteoporosis
- ◇ Rheumatoid Arthritis
- ◇ Lupus
- ◇ Psoriatic Arthritis

◇ Other: _____

Gastrointestinal
- ◇ Esophageal Reflux
- ◇ Ulcer
- ◇ Liver Disease
- ◇ Hepatitis
- ◇ Other: _____

Renal / Urinary
- ◇ Renal / Kidney Disorder
- ◇ Prostate Disorder
- ◇ Urinary Tract Disorder
- ◇ Urinary Incontinence? ◇ YES ◇ NO

If yes, type: _____

Skin
- ◇ Psoriasis

Infections / Diseases
- ◇ Lyme Disease
- ◇ MRSA (Drug Resistant Infection)
- ◇ HIV Disease
- ◇ AIDS
- ◇ STD

_____

Neuro / Psych
- ◇ Migraine Headache
- ◇ Epilepsy
- ◇ Seizures
- ◇ Depression
- ◇ Anxiety
- ◇ Bipolar Disorder
- ◇ Alcohol Dependence
- ◇ Drug Dependence
- ◇ Dementia

Endocrine / Hematologic
- ◇ Diabetes
- ◇ Gestational Diabetes
- ◇ HYPO-thyroidism
- ◇ HYPER-thyroidism
- ◇ HIV Infection
- ◇ History of Cancer: ◇ YES ◇ NO

If yes, please list:

_____

_____

_____

Other

_____

_____

_____

_____

_____

SURGICAL HISTORY: Please CHECK all that apply

◇ **NO HISTORY OF SURGERY**

ORTHOPEDIC

Shoulder
- ◇ Rotator Cuff Repair
- ◇ Shoulder Surgery
- ◇ Shoulder Replacement
- ◇ Other: _____

Hand / Wrist / Elbow
- ◇ Hand Surgery
- ◇ Carpal Tunnel Surgery
- ◇ Wrist Surgery
- ◇ Elbow Surgery
- ◇ Other: _____

Hip / Knee
- ◇ Knee Arthroscopy
- ◇ ACL Reconstruction
- ◇ Knee Surgery
- ◇ Knee Replacement
- ◇ Hip Surgery
- ◇ Hip Replacement
- ◇ Other: _____

Spine Surgery
- ◇ Epidural Spine Injection
- ◇ Laminectomy
- ◇ Discectomy
- ◇ Spinal Fusion
- ◇ Other Spine Surgery:

_____

_____

Foot / Ankle
- ◇ Ankle Surgery
- ◇ Foot Surgery
- ◇ Other: _____

NON-ORTHOPEDIC SURGERY
- ◇ Cataract Surgery
- ◇ Tonsillectomy
- ◇ Adenoidectomy
- ◇ Wisdom Tooth Extraction
- ◇ Thyroid Surgery
- ◇ Cardiac Stent Placement:

  Total number performed _____

  Date of most recent _____
- ◇ Open Heart: Bypass Surgery:

  Total operations performed _____

  Date of most recent _____
- ◇ Cardiac Pacemaker:

  Date of procedure: _____
- ◇ Appendectomy
- ◇ Gallbladder Surgery
- ◇ Hernia Repair Surgery: _____
- ◇ Hysterectomy
- ◇ D & C
- ◇ C-Section
- ◇ Prostate Surgery
- ◇ Other: _____

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FAMILY HISTORY: Please **CHECK** all that apply

	High Blood Pressure	Diabetes Mellitus	DVT/Blood Clot	Bleeding Disorder	Stroke	Asthma	COPD	Osteoarthritis	Osteoporosis	Cancer please list type below:
Mother										
Father										
Siblings										

ACTIVITY LEVEL: (Please rate)

♢ **INACTIVE** (normal activities of daily living)
♢ **LIGHT** (some activity; walking, gardening, occasional weekend recreational exercise)
♢ **MODERATE** (regular 3x per week moderate exercise, weekend athletics)
♢ **VIGOROUS** (regular 3-5x per week vigorous exercise and/or athletics weekly)
♢ **INTENSE** (competitive daily vigorous sports training)

SOCIAL HISTORY: Please **CHECK** all that apply

Do you smoke?		
♢ **Current smoker**	♢ **Former smoker**	♢ **Never a smoker**
How many cigarettes per day? _____	How many cigarettes per day? _____	
How many years? _____	How many years? _____	

Do you drink alcohol? ♢ **YES** ♢ **NO** **(If yes, please indicate below):**				
♢ Rarely	♢ Socially	♢ 1 drink per day	♢ 2-3 drinks per day	♢ 4 or more drinks per day

PAIN LEVEL: Please circle the number that best describes your current pain level on the chart below

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PRACTICE MANAGEMENT (Circle One):

1. Over the past 2 weeks how often have you experienced little interest/pleasure in doing things?

0-Not at all 1-several days 2-more than half the days 3-nearly every day

2. Over the past 2 weeks how often have you experienced feeling down, depressed or hopeless?

0-Not at all 1-several days 2-more than half the days 3-nearly every day

☐ I prefer not to answer these questions. Total Score =

1. Have you fallen in the last 6 months? ☐ Yes ☐ No
2. Do you feel steady on your feet? ☐ Yes ☐ No

REVIEW OF SYMPTOMS: Have you experienced any of the following symptoms over the past 6 months?

◇Recent Illness ◇Recent Weight Gain (___lbs.) ◇Recent Weight Loss (___lbs.) ◇Fever ◇Chills ◇Neck Pain / Stiffness ◇Cough ◇Shortness of Breath	◇Chest Pain or Discomfort ◇Palpitations ◇Heartburn / Indigestion ◇Nausea ◇Vomiting ◇Abdominal Pain ◇Diarrhea ◇Urinary Symptoms ◇Skin Rash	◇Easy Bleeding ◇Easy Bruising Tendency ◇Dizziness ◇Motor Disturbances ◇Sensory Disturbances ◇Joint Pain Stiffness ◇Joint Stiffness ◇Anxiety ◇Depression ◇Other: _____

I CERTIFY THAT THE ABOVE IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ _____

PATIENT'S SIGNATURE **DATE**

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Name _____ **Date of Birth** _____ **Age** _____

Reason for Visit

Are you: ☐ Right Handed ☐ Left Handed ☐ Ambidextrous

What is the reason for today's visit? _____

_____

Which side? ☐ *Right* ☐ *Left* ☐ *Both Sides*

When did the problem happen? _____

How did the problem happen? _____

Is your present complaint due to a motor vehicle/workers compensation accident? ☐ *Yes* ☐ *No*

If so, please describe the accident: _____

_____

If unable to work, please give dates: From _____ *to* _____

Please describe the nature of pain? *(Check all that apply)*: ☐ Constant ☐ Dull ☐ Burning ☐ Intermittent ☐ Sharp ☐ Radiating

Where does the pain radiate? _____

Associated symptoms *(Check all that apply)*: ☐ Clicking ☐ Swelling ☐ Locking ☐ Buckling ☐ Stiffness ☐ Weakness ☐ Difficulty using stairs ☐ Numbness/Tingling

Does the pain wake you at night? ☐ No ☐ Every Night ☐ Occasionally ☐ Rare

What makes it better? _____

What makes it worse? _____

Have you consulted any other physicians for this problem? ☐ Yes ☐ No

If yes, what physician(s) did you see? _____

Have you had any of the following imaging studies for your problem? *(Check all that apply)*:

☐ X-Ray ☐ CT Scan ☐ MRI ☐ Other: _____

Have you taken any medications for this problem? ☐ Yes ☐ No

If yes, what medications? _____

Any previous treatments/surgeries for this problem? ☐ Yes ☐ No

If yes, what treatments/surgeries? _____

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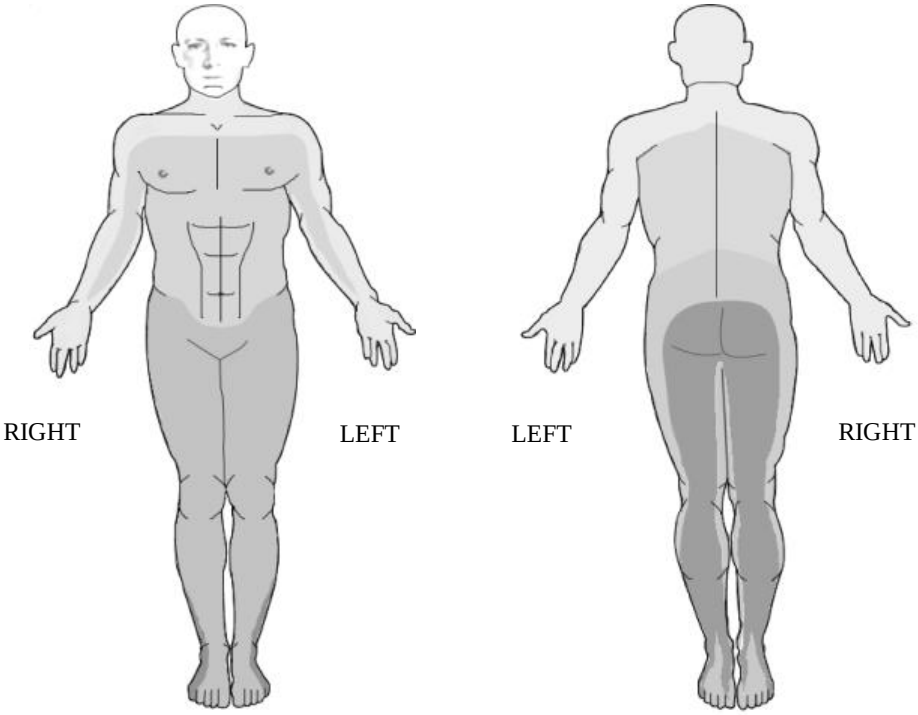
Using the appropriate symbols, mark all of the areas on your body where you feel the sensations described below

PAIN XXX **BURNING +++** **TINGLING •••** **NUMBNESS OOO**



I CERTIFY THAT THE ABOVE IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ _____

PATIENT'S SIGNATURE DATE

Physician use ONLY **NOTES**

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LAST NAME	FIRST NAME	MI	DATE OF BIRTH	AGE	SOCIAL SECURITY #

STREET ADDRESS/ P.O. BOX	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE	SEX M F	MARITAL STATUS M W S D CU

EMAIL ADDRESS	PHONE # TO BEST CONTACT YOU: ☐ Home ☐ Work ☐ Cell	RELATIONSHIP TO RESPONSIBLE PARTY ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other

EMPLOYER	EMPLOYER STREET ADDRESS	CITY	ZIP

PRIMARY PHYSICIAN, ADDRESS & PHONE NUMBER	NAME OF CUSTODIAL PARENT

RACE	ETHNICITY ☐ ☐ **Latino/Hispanic** **Other** **Not Reported/Refused**	LANGUAGE

GUARANTOR/RESPONSIBLE PARTY: (If different from above)

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY #

STREET ADDRESS/ P.O. BOX	CITY	STATE	ZIP

EMAIL ADDRESS	HOME PHONE	WORK PHONE	CELL PHONE

EMPLOYER	EMPLOYER STREET ADDRESS	CITY	ZIP

EMERGENCY CONTACT:

NAME	PHONE	RELATIONSHIP
NAME	PHONE	RELATIONSHIP

INSURANCE/POLICY HOLDER INFORMATION: (Please present insurance cards to receptionist)

PRIMARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER NAME	SEX ☐ M ☐ F	POLICY HOLDER BIRTHDATE
POLICY NUMBER	GROUP NUMBER	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other		CO-PAY AMOUNT

SECONDARY INSURANCE:

PRIMARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER NAME	SEX ☐ M ☐ F	POLICY HOLDER BIRTHDATE
POLICY NUMBER	GROUP NUMBER	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other		CO-PAY AMOUNT

PHYSICIAN TREATING YOU TODAY:	REFERRED BY:

IS THIS INJURY/ACCIDENT RELATED TO: ☐ WORK ☐ MOTOR VEHICLE ☐ SCHOOL ☐ OTHER	
DATE OF INJURY/ACCIDENT	CLAIM NUMBER

I the undersigned give my authorization to treat and assign directly to Tri-County Orthopaedics & Sports Medicine, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature of patient or patient's representative

Date

Tri-County Orthopedics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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X-RAY REQUEST POLICY

It is the policy of this practice that upon request, we will provide you with a copy of your x-rays on a CD disc.

If you need the actual films from your exam, it is always $15.00 for 1-3 sets. For each additional set it is always $5.00. If requesting an older set of films that were not done digitally they are free, but must be returned when you are finished with them. These films which were done in our office are stored for 7 years. After this time period they will be destroyed.
Please be reminded that we need 72 hours to process your request.

Be aware that films not taken in this office are the responsibility of the patient. Please take them with you. They are your property. If left in our facility, they will only be stored for 3 years. After this time period they will be destroyed.

If you are a Worker's Comp patient, please contact your case manager to get authorization for any films to be rendered to you.

If a request for x-rays is submitted. Pick up must be within 30 days otherwise a new request must be submitted.

I acknowledge that I have read the X-Ray Request Policy.

_____
Print Name of Patient or Legal Guardian

_____ _____
Signature Date

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CONSENT to the USE AND DISCLOSURE OF HEALTH INFORMATION
For the TREATMENT, PAYMENT, HEALTHCARE OPERATIONS & FINANCIAL POLICY

I _____ understand that as part of my treatment, Tri-County Orthopedics
(Patient Name)
originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any future care or treatment. I understand that this information serves as:

- Basis for planning my care and treatment.
- A means of communication among any other health professionals who might contribute to my care, i.e.: via facsimile, telephone, etc.
- A source of information for applying diagnosis and surgical information to my account to process for payment.
- A means by which a third-party payer can verify that services billed and accurate and actual.
- As a tool for routine healthcare operations, such as assessing quality, and reviewing the competence of healthcare officials.
- A means by which an insurance appeal at any stage, may be filed.
- You are responsible to supply our staff with any and all insurance identification card(s) at the time of your appointment. If your insurance carrier requires a referral from your primary doctor, it is you're responsibility to present this to our receptionist prior to your visit, as we cannot bill your insurance company without it. If you do not obtain a referral when your insurance requires one, you will be required to pay for the visit in full at the time of visit. All co-pays are to be collected prior to your visit.
- Any outstanding balance for which a patient is responsible is due within 30 days of billing. Any patient balance that has gone 90 days without a patient payment is subject to immediate collection process. Services that are transferred to a collections status will be subject to a $50.00 service fee per occurrence.
- A returned check fee of $35.00 will be applied to any account for checks returned to us for insufficient funds.
- I assign all benefits for my medical services to Tri-County Orthopedics.

I understand Tri-County Orthopedics will take care to ensure that any and all information pertaining to me and my treatment at this facility will be handled with an emphasis on maintaining my privacy at all times. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that this facility is not required to agree to these restrictions in the event of an emergency. I understand that I may revoke this consent in writing at any time, but not to the extent the organization has already acted in.

- I authorize Tri-County Orthopedics to release my medical records to the following **friend** or **family member**:

  Name: _____Relationship:_____

  Name: _____Relationship:_____

_____
Print Name of Patient or Legal Guardian

_____ _____
Signature Date

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TRI-COUNTY ORTHOPEDICS ASSIGNMENT OF BENEFITS FORM

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. I understand that I am financially responsible to Tri-County Orthopedics ("TCO") for any charges not covered by health care benefits. It is my responsibility to notify TCO of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by TCO and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for professional services received.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled, to TCO. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to TCO for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

I hereby assign my rights, title and interest under the medical expense section and/or PIP section of my insurance policy to TCO to bring a lawsuit or arbitration against my insurance carrier(s). This allows TCO to retain an attorney of their choice to filing litigation or arbitration for any unpaid medical expenses, and/or denied proposed medical treatment, against my insurance carrier, or any other company, against which I may proceed for medical expense benefits.

Unless revoked, this assignment is valid for all administrative and judicial reviews under the Patient Protection and Affordable Care Act, ERISA, Medicare and applicable federal or state laws.

Authorization to Release Information

I hereby authorize TCO to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment, including but not limited to filing arbitration/litigation in TCO's name on my behalf; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from TCO on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

_____

Print Name Patient/Responsibility

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