TENNESSEE ORTHOPAEDIC CLINICS

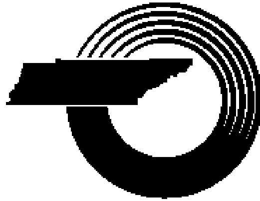
PATIENT INFORMATION

Today's date:		Doctor You Are Seeing:		
Have you been to our offices before? If yes, when? By Whom?				
Patient's Full Name:				
Street address:		City/State/Zip:		
Home phone:	Email:	Social Security #:	Sex: ❑ M ❑ F	Date of Birth:
Marital Status: Single / Mar / Div / Sep / Wid				
Employer		Work #:	Occupation:	
Employer's Address:		Is Patient a Student?	Where:	
Spouse's Name:		Spouse's Employer:	Work #:	
Emergency Contact Person (or next of kin not living with you):		Address:	Phone #:	
INFORMATION ABOUT ILLNESS OR INJURY				
Was injury caused by accident? Yes / No Date:	Injury Occurred: ❑ Due to Auto Accident? ❑ On the job ❑ Other		State where auto accident occurred:	Date of First Symptom:
Patient Seen in Emergency Room? Yes/ No Date:	Which Hospital?	How did You Hear About Our Office? ❑ Family/Friend ❑ Yellow Pages ❑ Insurance Co. ❑ Radio ❑ Attorney ❑ Employer ❑ Newspaper ❑ Other		
Body Part to be Examined/Complaint:				
Name of Referring Physician:		Address:		
Name of Primary Care Physician:				
GUARANTOR NAME (RESPONSIBLE FOR PAYMENT) **Check one:** ❑ Self ❑Spouse ❑ Mother ❑ Father ❑ Employer ❑ Other				
Full Name:	Home Phone:	Date of Birth:	Social Security #	
Address:				
Employer:	Work Phone:	Occupation:		
Employer's Address:				

PATIENT/GUARDIAN SIGNATURE ________________________ DATE ________________

Primary Insurance			**Secondary Insurance**		
Insurance Company Name:			Insurance Company Name:		
Group #	ID#		Group #	ID#	
Name of Insured	Date of Birth		Name of Insured	Date of Birth	
Policy Holder Address			Policy Holder Address		
Phone:	Social Security:	Sex:	Phone:	Social Security:	Sex:
Policy Holder Employer:			Policy Holder Employer:		
Patient's Relationship To Insured:			Patient's Relationship To Insured:		
Referral Information			**Method of Payment**		
Does your insurance require a referral from a primary care physician? Yes / No If yes, has the referral been obtained? Yes / No			❑ Cash ❑ Check ❑ Credit Card		

Updated____________ ________ Emp Int Updated____________ ________ Emp Int Updated____________ ________ Emp Int



ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of any medical information necessary for the processing of insurance claims. I hereby assign all medical benefits to include major medical benefits to which I am entitled to Tennessee Orthopaedic Clinics, P.C. this will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. I further agree to be solely responsible for any balances that my insurance does not pay.

Signature: Date:

REFERRAL INFORMATION:
I understand that if a referral is required by my primary physician, I am responsible for obtaining this referral and following the rules/regulations of my insurance provider. I understand that failure to obtain my referral could result in my responsibility for payment of services rendered.

Signature: Date:

In the event this account is turned over for collection, patient (or responsible party) agrees to pay for all costs of collections, including court costs and attorney's fees.

Signature: Date:

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages and other forms of communications.

Signature: Date:

TOCCORP 070 Rev. 10/10

I, ______________________________, give TOC permission to disclose my health information and account information to: Please list all parties we may discuss this information with (spouse, other family members, etc), including yourself if the patient is a minor. ***Please give full names.***

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Where and how may we contact you?

	Yes	**No**	
Home			If yes, please give phone number ______________________
Work			If yes, please give phone number ______________________
Email			If yes, please give us your email address ______________________
Other/Cell			If yes, please give us another contact number ______________________

May we leave a message on your answering machine or voicemail?

At Home? Yes   At Work? Yes No

May we leave a message if there is no answering machine?

At Home? Yes   At Work? Yes No

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Signature of patient or responsible party   Date

PROOF NOTICE OF PRIVACY POLICIES RECEIVED

Your Rights Regarding Your Protected Health Information

We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our legal duties and privacy practices with respect o protected health information. We are required to abide by the terms of the Notice currently in effect. We reserve the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. If we change the Notice, we will provide a copy to the revise notice through in-person contact.

Your Rights Regarding Your Protected Health Information

You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated.

If you wish to complain to us, please do so in writing, and direct your complaint to the Privacy Officer.

You will not be penalized for filing a complaint

Contact Information

PLEASE CONTACT THE PRIVACY OFFICER AT THE SITE YOUR SERVICE WERE GIVEN

Effective Date

This Notice is effective April 14, 2003

Please print name Account#

Signature of patient or responsible party Date

TOC PATIENT HISTORY

NAME ____________________ DATE __________ AGE _____ REFERRED BY ____________________

What's the problem? ____

____

____

When did it start? ____________________________ Have you been treated for this problem? Yes No

What was the treatment? ____

____

Any special tests (MRI, CT scan, bone scan, nerve tests, bone density, etc.)? _______________

____

Have you had this problem before? ____

If work-related: Employer ______________________________ Current job ____________________

Are you working now? __________________ Regular or light duty? ________________

Did you have an accident at work? ____

Do you have a lawyer for this? ____

REVIEW OF SYSTEMS: (circle)

Constitutional
unexplained weight loss
fever / chills
night sweats

Eyes
blurry vision
wear glasses
blind / color blind

Ears, Nose, Mouth, Throat
hearing problems / deaf
can't taste / can't smell
swallowing problems
sore throat

Cardiovascular
chest pain
irregular heartbeat
poor circulation
exercise problems

Respiratory
shortness of breath
coughing

Gastrointestinal
heartburn
nausea / vomiting
constipation
diarrhea
blood in stool

Genitourinary
can't control bladder
can't urinate
blood in urine

Skin / Breast
rash
hair loss
bruising
breast lump

Musculoskeletal
muscle, bone, joint swelling
broken bones
pain in arm, leg, neck, back

Neurologic
headache
weakness
numbness
dizziness

Psychiatric
depression
anxiety

Endocrine
too hot / too cold
can't take stress
gland problems

<u>Allergy / Immunologic</u>
frequent colds, infections, allergies
hives

<u>Hematologic / Lymphatic</u>
easy bruising or bleeding
lumps in neck, armpit, or groin
anemia

MEDICAL HISTORY: Have you had any of the following? (circle)

cancer, radiation, chemotherapy
HIV / Aids
hepatitis
diabetes - insulin / no insulin
asthma
emphysema / bronchitis / COPD
tuberculosis
<u>Are you pregnant</u>?
thyroid problems

blood clot
bleeding problems
hemophilia
sickle cell anemia
ulcers
high blood pressure
heart disease
other ____________________

SURGICAL HISTORY: What operations have you had? Please give dates.

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FAMILY HISTORY: Do your immediate relatives have any of the following conditions?

cancer
arthritis
kidney disease
tuberculosis

bleeding problems
hemophilia
sickle cell anemia
any other disease ____________________

SOCIAL HISTORY (circle) single / married / divorced / widowed

What is your occupation? ____________________

How much alcohol do you drink? ____________________

How much do you smoke? ____________________

Have you ever been addicted to drugs? ____________________

Are you on disability? ____________________

WHAT MEDICATIONS ARE YOU TAKING? (remember birth control, vitamins, etc.)

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WHAT MEDICATIONS / OTHER THINGS ARE YOU ALLERGIC TO? ____________________

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