



PATIENT INFORMATION

Form containing patient information fields: Today's date, Doctor You Are Seeing, Patient's Full Name, Street address, City/State/Zip, Home phone, Email, Social Security #, Sex, Date of Birth, Marital Status, Employer, Work #, Occupation, etc.

PATIENT/GUARDIAN SIGNATURE

DATE

Form containing insurance and payment information: Primary Insurance, Secondary Insurance, Referral Information, Method of Payment.

Updated _____ Emp Int Updated _____ Emp Int Updated _____ Emp Int



TENNESSEE ORTHOPAEDIC CLINICS

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: _____



TENNESSEE ORTHOPAEDIC CLINICS



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.**

Where and how may we contact you?

	Yes	No	
Home	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please give phone number _____
Work	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please give phone number _____
Email	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please give us your email address _____
Other/Cell	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please give us another contact number _____

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

At Home?	Yes <input type="checkbox"/>	<input type="checkbox"/>	At Work?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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May we leave a message if there is no answering machine?

At Home?	Yes <input type="checkbox"/>	<input type="checkbox"/>	At Work?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Signature of patient or responsible party Date



TENNESSEE ORTHOPAEDIC CLINICS

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 to 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 revised 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



PATIENT HISTORY FORM

Vital Signs Ht: _____
Pulse: _____ Wt: _____
Resp: _____ BP: _____

****Please bring all your medication bottles with to the appointment.**

****If you have had any x-rays, MRIs or other studies, then please bring the films with you to the appointment unless they were done at Methodist Medical Center.**

Name: _____ Date: _____ Age: _____ Sex: Female Male
Family Physician: _____ Other Physicians: _____

What's the problem? _____

When did it start: _____ Any treatment? Yes _____ No _____
What was the treatment: _____

Any special tests (X-Rays, MRI, CT, Bone scan, etc.)? _____

Have you had this problem before? _____
Auto Accident? Yes No Work Comp? Yes No
Date of Injury: _____ Are you currently working? Yes No

Medical History: Have you had any of the following? (Circle)

Cancer, radiation, chemotherapy	Tuberculosis	Ulcers
HIV/AIDS	Thyroid problems	High Blood Pressure
Hepatitis	Blood Clot	Heart Disease
Diabetes - insulin	Bleeding problems	Are you pregnant?
Asthma	Hemophilia	Other:
Emphysema/Bronchitis/COPD	Sickle cell anemia	

Surgical History: What operations have you had? Please give dates: _____

Problems with anesthesia? Yes No

Medications: Please bring a current list of all medications including dosages.

Medical Allergies: _____

Family History: (circle)

Cancer	Tuberculosis	Sickle Cell Anemia	Other Diseases:
Arthritis	Bleeding Problems	Heart problems	
Kidney Disease	Hemophilia	Diabetes	

Social History: Single Married Divorced Widowed

Occupation: _____ Employer: _____

Job Duties: _____

Are you on disability? Yes No Will this effect your work: Yes No

How much alcohol do you drink? _____

Do you use tobacco products: Yes No What? _____ How much? _____

Have you ever been addicted to drugs? Yes No What? _____

REVIEW OF SYSTEMS:

Constitutional

Unexplained weight loss

Fever/chills

Night sweats

Endocrine

Too hot, too cold

Can't take stress

Gland problems

Hematological/Lymphatic

Easy bruising or bleeding

Lumps in neck, armpit or groin

Anemia

Cardiovascular

Chest pain

Irregular heartbeat

Poor circulation

Exercise problems

Skin/Breast

Rash

Hair loss

Bruising

Breast lump

Ears, Nose, Throat, Mouth

Hearing problems/deaf

Can't taste/can't smell

Swallowing problems

Sore throat

Genitourinary

Can't control bladder

Can't urinate

Blood in urine

Eyes

Blurry vision

Wear glasses

Blind/color blind

Musculoskeletal

Muscle, bone joint swelling

Broken bones

Pain in arm, leg, neck, back

Gastrointestinal

Heartburn

Nausea/vomiting

Constipation

Diarrhea

Blood in stool

Neurological

Headaches

Weakness

Numbness

Dizziness

Allergy/Immunologic

Frequent colds, infections, allergies

Hives

Respiratory

Shortness of breath

Coughing

Psychiatric

Depression

Anxiety

CHECKLIST OF ITEMS TO HAVE AT THE TIME OF YOUR APPOINTMENT:

Copy of insurance card

List of current medications and dosages

Film or disc of any recent studies (MRI, x-ray, etc.)

This form

Any medical records of past treatment that you may have