



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: \_\_\_\_\_



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?**

	<b>Yes</b>	<b>No</b>	
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

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Please print name

Account#

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Signature of patient or responsible party

Date

Your First Visit and Medical History

Today's Date \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F

Occupation: \_\_\_\_\_ Dominant Hand: \_\_\_\_\_ Referring Dr. \_\_\_\_\_

**Tell Us About Your Symptoms**

**Check the correct statement:**

- I was injured at work
- I was injured in another type of accident
- I do not recall an injury

**I was injured the following way:**

- Lifting  Bending
- Falling  Twisting
- Auto Accident
- Other (please specify) \_\_\_\_\_

When did these symptoms begin (date)? \_\_\_\_\_

Is the pain constant? Or does it come and go? \_\_\_\_\_

Have you had this problem before? \_\_\_\_\_

How do these symptoms limit/restrict you? \_\_\_\_\_

**My arm pain is:**

- No arm pain  I have arm weakness
- Worse than my neck pain  I have arm numbness
- The same as my neck pain
- Not as bad as my neck pain

**My leg (or hip or buttock) pain is:**

- No leg pain  I have leg weakness
- Worse than my back pain  I have leg numbness
- The same as my back pain
- Not as bad as my back pain

Who has treated you for this problem?

Dr. \_\_\_\_\_ City: \_\_\_\_\_

Dr. \_\_\_\_\_ City: \_\_\_\_\_

What tests have you had (circle all that apply):

CT scan   MRI   EMG   Bone scan   Myelogram

Did you have any injections for your problem? Yes / No

Did you have previous neck or back surgery? Yes / No

Have you had physical therapy for this problem? Yes / No

Are you doing exercises for your neck or back? Yes / No

Date last worked: \_\_\_\_\_ full duty / light duty

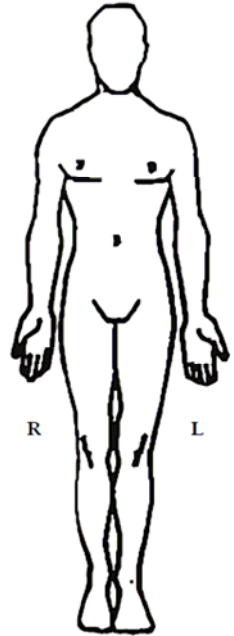
Does your job require lifting, bending, standing, sitting?

Describe: \_\_\_\_\_

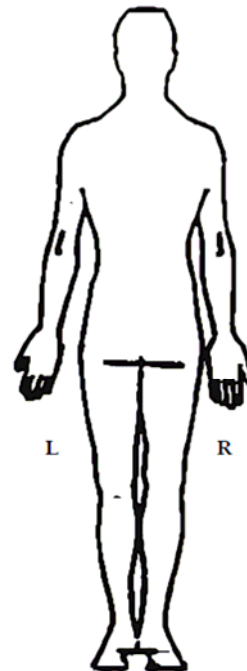
**Front:**

Draw your pain on the diagrams.  
Use the corresponding symbols to show the type of pain you feel.

- Stabbing pain    ///
- Burning pain    000
- Aching pain     xxx
- Pins & Needles   vvv
- Numbness       -----



**Back**



Circle your pain level. 1=No pain 10=Unbearable  
1   2   3   4   5   6   7   8   9   10

**Your First Visit and Medical History**

List all current medications you are taking (dose and frequency)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all over the counter medications and oral steroids you have taken for these symptoms: \_\_\_\_\_

\_\_\_\_\_

List all ALLERGIES you have to food, medications, including Steroids, IVP Dye / Iodine, etc: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever had any of the following medical problems: (check all that apply – explain as needed)

- AIDS / HIV
- Arthritis
- Bleeding disorders
- Cancer
- Diabetes
- Epilepsy
- Heart problems
- Hepatitis
- High Blood Pressure
- Alzheimer’s Disease
- Other: \_\_\_\_\_

- Headaches
- Muscle diseases
- Nerve problems
- Psychiatric problems
- Stomach problems
- Thyroid problems
- Kidney problems
- Alcohol / drug abuse
- Stroke

\_\_\_\_\_

List all previous surgeries and the dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Marital Status: Single Married Divorced Widowed

Do you smoke? Yes No Amount:

Do you drink? Yes No Amount:

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

FOR OFFICE USE:

HT \_\_\_\_\_ WT: \_\_\_\_\_ TEMP: \_\_\_\_\_ PULSE: \_\_\_\_\_ RESP: \_\_\_\_\_

Do any family members have a history of: (check all that apply)

- Headaches
- Arthritis
- Bleeding disorders
- Cancer
- Diabetes
- Epilepsy
- Heart problems
- Alcohol/Drug abuse
- High Blood Pressure
- Other: \_\_\_\_\_
- Alzheimer’s Disease
- Muscle diseases
- Nerve problems
- Psychiatric problems
- Stomach problems
- Thyroid problems
- Kidney problems
- Spine problems
- Stroke

**REVIEW OF SYSTEMS**

Are you affected with or troubled by:

- Weight loss
- Fatigue
- Chills
- Vision changes
- Fainting
- Trouble breathing
- Swelling
- Menstrual/GYN
- Anemia
- Memory loss
- Skin problems
- Sexual problems
- Coordination probs
- Hearing loss
- Weakness
- Fever
- Sweats
- Dizziness
- Chest pain
- Circulatory problems
- Diarrhea
- Abdominal pain
- Bleeding tendency
- Mental changes
- Headaches
- Sleeping difficulties
- Thirst
- Vomiting

**Are you pregnant? Yes / No**

**Have you lost any control over bladder or bowel functions? Yes / No**