



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



Medical History

City of Residence: _____

Occupation: _____

Patient Name: _____ Account # _____

Height: _____ Weight: _____ Age: _____ Gender: M F (R L Handed)

Referred By: _____ Primary Care Dr.: _____

Present complaint: Painful Area(s) _____

Motor vehicle accident? Yes No Work Related? Yes No Date of Injury _____

If due to an injury or accident, give details of event _____

Have you ever had problems with this area before? Yes No If yes, explain _____

Are you currently seeing a physician, therapist, chiropractor, podiatrist, etc. for this problem?

Yes No If yes, please list: _____

Allergies: _____

Latex Allergy? Yes No

Pain Management Clinic? Yes No

CURRENT MEDICATIONS (ex: Digoxin 0.25 mg 1x/Daily)

<u>Drug</u>	<u>Dose</u>	<u>Frequency</u>	<u>Drug</u>	<u>Dose</u>	<u>Frequency</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Office Note:

Signature _____ Date _____ Updated _____ Initials _____ Updated _____ Initials _____

Name: _____ Date: _____

Medical Problem List

Mark all applicable boxes

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Congestive Heart | <input type="checkbox"/> Failure High Blood Pressure | <input type="checkbox"/> Pulmonary Embolus |
| <input type="checkbox"/> Blood Clot/D.V.T. | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> High Thyroid | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression | <input type="checkbox"/> Low Thyroid | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Lung | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Skin | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Lupus | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mini-strokes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Renal | <input type="checkbox"/> GERD | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ulcer Disease |
| <input type="checkbox"/> Myeloma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Neuropathy | |
| <input type="checkbox"/> Other | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Cardiac Pacemaker/
Defibrillator | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Panic Attack | |

Please list other problems:

List All Surgeries (ex: Appendectomy – 1963)

List All Surgeries (ex: Appendectomy – 1963)

FAMILY HISTORY: Do your immediate relatives have any of the following conditions? If so, please mark all applicable boxes.

- | | | |
|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Anesthetic Complication |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pulmonary Embolus (PE) |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Any Other Disease _____ |

SOCIAL HISTORY: Place mark in appropriate box for each question

- Single Married Divorced Widowed

Alcohol Consumption per Week? None 1-3 3-4 more than 6

Do you smoke? No Yes If yes, how many packs per day? _____ How long? _____

Are you on disability? No Yes

REVIEW OF SYSTEMS:

Constitutional

- Unexplained weight loss
- Fever/chills
- Night sweats

Cardiovascular

- Chest pain
- Irregular heartbeat
- Poor circulation
- Exercise problems

Genitourinary

- Can't control bladder
- Can't urinate
- Blood in urine

Gastrointestinal

- Heartburn
- Nausea/vomiting
- Constipation
- Diarrhea
- Blood in stool

Respiratory

- Shortness of breath
- Coughing

Endocrine

- Too hot, too cold
- Can't take stress
- Gland problems

Skin/Breast

- Rash
- Hair loss
- Bruising
- Breast lump

Eyes

- Blurry vision
- Wear glasses
- Blind/color blind

Neurological

- Headaches
- Weakness
- Numbness
- Dizziness

Psychiatric

- Depression
- Anxiety

Hematological/Lymphatic

- Easy bruising or bleeding
- Lumps in neck, armpit or groin
- Anemia

Ears, Nose, Throat, Mouth

- Hearing problems/deaf
- Cant' taste/can't smell
- Swallowing problems
- Sore throat

Musculoskeletal

- Muscle, bone joint swelling
- Broken bones
- Pain in arm, leg, neck, back

Allergy/Immunologic

- Frequent colds, infections, allergies
- Hives

HOBBIES/INTERESTS: _____

Signature _____ Date _____ Updated _____ Initials _____ Updated _____ Initials _____