



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

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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.**

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

Appointment Time _____

Date _____

NEW COMPLAINT INFORMATION

Name _____ Age _____ Sex _____ Height _____ Weight _____

Are you right or left handed? _____ Student _____ Occupation _____

Present complaint: Painful area(s) _____

Referred by: _____

Was your injury the result of either a Work Related Incident or a Motor Vehicle Accident? _____

If "Yes", please choose either Work Related or Motor Vehicle Accident _____

If "Yes", date of your injury _____ If "No", how long have symptoms been present _____

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

Have you ever had problems with this area before? _____ If "Yes", explain: _____

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

If "Yes", please list _____

List any medications you are taking for your present problem: _____

Are you pregnant? _____

TURN OVER TO COMPLETE

GENERAL MEDICAL HISTORY

Name _____ Date _____

Please list all medications you take on a regular basis.

MEDICATION	DOSAGE	HOW OFTEN	REASON
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List any anti-inflammatories you have tried (prescription or over the counter).

Are you allergic to any medications, foods, or dyes? _____ If "Yes", please list _____

Please circle any of the following conditions that you have had or have now.

Heart Attack	Renal Failure	HIV/AIDS
Angina	Cancer	Steroids/Drug Abuse
Congestive Hear Failure	Ulcers	Venereal Disease
High Blood Pressure	Gallbladder Disease	Urinary Tract Infections
Stroke	Intestinal Disease	Bleeding Disorder
Pneumonia	Hemorrhoids	Diabetes
Emphysema	Liver Cirrhosis	Gout/Pseudogout
Collapsed Lung	Prior Blood Transfusions	Depression
Chronic Bronchitis	Hepatitis	Psychological Treatment
Kidney Disease	Tuberculosis	Cardiac Arrhythmia

Please circle any of the following symptoms that you have had in the past 2 years.

Chest Pain	Bloody Sputum	Shortness of Breath
Irregular Heart Beat	Vomited Blood	Hand Swelling
Dizziness	Unplanned Weight Loss	Foot Swelling
Passing Out	(over 20 pounds)	Sinusitis
Bloody Stools	Difficulty Passing Urine	Night Sweats

If "Yes", please explain _____

Does anyone in your family have Diabetes, Arthritis, or Tuberculosis? _____ If "Yes", explain _____

Do you smoke? _____ If "Yes", how many packs per day? _____ How long? _____

Average alcohol intake weekly: None _____ 1-3 drinks _____ 4-10 drinks _____ Over 10 Drinks _____

Have you been hospitalized in the past 5 years or ever had surgery? _____ If "Yes", explain _____

TURN OVER TO COMPLETE

Appointment Time _____

Date _____

NEW PATIENT INFORMATION

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