POWELL & JONES ORTHOPEDICS CENTER, P.C. ***(PLEASE PRINT AND USE BLUE OR BLACK INK)***

Patient Account# _____ Employee Initials _____

Patient's Name (Last, First, Middle Initial) _____

Responsible Party (if minor) _____

Address _____ City _____ State _____ Zip _____

Primary Phone No. _____ Secondary Phone No. _____

E-mail Address _____

Date of Birth _____ Age _____ Sex M ❑ F ❑ Full Time Student: Y ❑ N ❑

Social Security No. _____ Guarantor's Social Security No. _____

Employed: Y ❑ N ❑ Employer _____ Race _____ Ethnicity _____ Primary Language _____

Emergency Contact & Relationship _____ **Phone No ( )** _____

Primary Care Physician _____ Phone No ( ) _____

Referring Physician _____ Phone No ( ) _____

Pharmacy Name: _____ Phone No ( ) _____

Do you have an advance directive (ex. Living Will, Power of Attorney, Organ Donor) in place? **Yes** **No** (Please circle one)

PRIMARY INSURANCE COMPANY _____

Address _____ City _____ State _____ Zip _____

Policy No. _____ Group No. _____ Effective Date _____

Policy Holder's Name _____ Date of Birth _____ Relation to Patient _____

Policy Holder's Employer _____ Policy Holder's Address. _____

SECONDARY INSURANCE COMPANY _____

Address _____ City _____ State _____ Zip _____

Policy No. _____ Group No. _____ Effective Date _____

Policy Holder's Name _____ Date of Birth _____ Relation to Patient _____

Policy Holder's Employer _____ Policy Holder's Address _____

CONSENT FOR USE AND DISCLOSURE OF INFORMATION (Please Read and Sign Below)

By signing below, you consent to our use and disclosure of your protected health information for treatment, payment, and health care operation. including but not limited to, review of your complete pharmacy record. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent. I Hereby give my consent for Powell & Jones Orthopedics Center, PC, to furnish information to insurance carriers concerning my physical condition and treatments. and I hereby assign to the Physicians all payments for Medical Services rendered to myself or my dependents.

I understand that I am responsible for all fees and finance charges for the above named patient, regardless of Insurance coverage. If, after default. this account is placed in the hands of a collection agency. the undersigned agrees to pay 30% of the unpaid balance as a reasonable collector's fee, together with the additional costs and expenses of collection to the extent permitted by law.

Signature _____ **Date** _____

ACKNOWLEDGMENT OF NOTIFICATION OF PRIVACY PRACTICES (Please Read and Sign Below)

By signing below. you acknowledge the availability of our Notice of Privacy Practices pamphlet. which provides information about how we may use and disclose your protected health information, and is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We reserve the right to change the terms described. and should we do this we will post the changes in all of our offices. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment. payment. or health care operations. We are not required to agree with your restrictions: but if we do. we are bound by our agreement with you.

Signature _____ **Date** _____

POWELL & JONES ORTHOPEDICS CENTER

Patient Name: _____ **Date of Birth:** _____

I authorize Powell & Jones Orthopedics Center to discuss my medical information with the following:

PLEASE LIST THE PERSON'S NAME AND PHONE NUMBER IN ORDER FOR US TO RELEASE ANY INFORMATION

◯ None _____ ◯ Parents _____

◯ Spouse _____ ◯ Mother (only) _____

◯ Father (only) _____ ◯ Guardian _____

◯ Other _____ ◯ Relationship to patient _____

I wish to be contacted by Powell & Jones Orthopedics Center in the following manner (check all that apply)

◯ Telephone _____
◯ Okay to leave message with detailed information
◯ Leave brief message only
◯ Other (email address) _____

The HIPAA Privacy Act generally requires healthcare providers to take responsible steps to limit the disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses and disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute and adequate record. Uses and disclosures of protected health information may be permitted without prior consent in an emergency.

ACKNOWLEDGMENTS:

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Personal Representative's relationship to the Patient Signature of Witness

_____
PRINT Personal Representative's Name

Patient Name:

Medical History (your health)

- o None
- o High blood pressure
- o Heart disease
- o Diabetes
- o Asthma
- o Thyroid disease
- o Hypothyroidism (Low)
- o Hyperthyroidism (High)
- o Peptic ulcer disease
- o Acid reflux
- o Cancer (type: _____)
- o Stroke
- o Kidney disease
- o Liver disease
- o Seizures
- o Other_____

Medications: please list current medications and dose:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies:

- o None
- o Penicillin
- o Sulfa
- o Aspirin
- o Codeine
- o Other(s):

_____
_____
_____
_____
_____

Yes/No: Egg Allergy?

Yes/No: Currently taking blood thinner?

Yes/No: Do you have a pacemaker?

Current Vitals:

Height: ___ft, ___ in

Weight: _____ lbs

OFFICE USE ONLY:

BP: _____

RR: _____

Surgical History

1. _____ DATE: _____
2. _____ DATE: _____
3. _____ DATE: _____
4. _____ DATE: _____
5. _____ DATE: _____
6. _____ DATE: _____

Family History: "What runs in your family?"

Mother Alive/Deceased (Please circle one)
Father Alive/Deceased (Please circle one)

Mother		Father
_____	Heart Disease	_____
_____	High Blood Pressure	_____
_____	Diabetes	_____
_____	Cancer	_____
_____	Arthritis	_____
_____	Other:	_____

Social History

Do You Smoke?
- o No
- o Yes: ____ pack(s) a day

Have you had an alcoholic drink:
- o In the past year
- o In the past month
- o This week

Marital Status:
- o Single
- o Married
- o Divorced
- o Widowed
- o Other: _____

Are you currently experiencing any of the following (check all that apply). If none apply, check here ___.

General:
- o Weight loss
- o Fevers
- o Fatigue
- o Cancer

Cardiovascular:
- o Chest pain
- o Irregular rhythm
- o Heart murmur

Gastrointestinal:
- o Heartburn with aspirin
- o Acid Reflux
- o Stomach ulcers
- o Hepatitis
- o _____

Musculoskeletal:
- o Arthritis
- o Osteoporosis
- o Prior fracture
- o _____

Neurologic:
- o Balance problems
- o Dizziness
- o Weakness
- o Headaches
- o Seizures
- o Stroke

Eyes:
- o Glasses/contacts
- o Glaucoma
- o Macular degeneration
- o Cataracts

Ear/Nose/Throat
- o hearing loss
- o sinus infections

Respiratory
- o shortness of breath
- o sleep apnea
- o _____

Urinary
- o Painful urination
- o Urinary infections
- o Urinary frequency

Endocrine
- o Diabetes
- o Hyperthyroidism
- o Hypothyroidism

Skin Rash
- o Rash/sores
- o psoriasis

Hematologic
- o bleeding problems
- o blood clots
- o pulmonary embolism

Immunologic
- o tuberculosis
- o HIV infections

Psychiatric:
- o Depression
- o Anxiety
- o Panic attacks
- o _____

Women only: Currently Pregnant? Yes/No Breast feeding? Yes/No Date of last menstrual period: ___/___/___

To the best of my knowledge the information provided is accurate.

Patient/Responsible Party Signature: _____ Date: ___/___/___

POWELL & JONES ORTHOPEDICS CENTER

■ Patient Name (Print) _____ ❑ M ❑ F Age

Dominant Hand: ❑ R ❑ L ❑ AMB

■ Who recommended that you visit this office? _____(Name)

■ ❑ MD ❑ Other Healthcare Provider ❑ Attorney

■ What body part is involved? _____ ❑ R ❑ L

Did you bring X-Rays? ❑ Y ❑ N

■ What is the main reason for this visit? ❑ Pain ❑ Numbness ❑ Weakness ❑ Swelling ❑ Stiffness ❑ Other

■ When did it start? (Please provide the date) _____

■ Where did the injury happen? _____

■ Have you had a problem like this before? ❑ Y ❑ N If so, when and who treated you for this problem:

_____

■ **Is this a WORK RELATED INJURY?** _____

■ **Is this injury related to a MVA (Motor Vehicle Accident)?** _____