Patient Acct # _____-_____ ☐ New ☐ Established

Personal Insurance Registration

##########

Patient's Last Name: _____First: _____Mid Int.:_____

Social Security #:_____ ☐ Male ☐ Female Age: _____

Address:_____

City/State/Zip: _____

Date of Birth: _____Home Phone#:_____Email: _____

Work Phone: _____ Cell Phone#:_____

Notify in case of emergency: _____Relation:_____

Address: _____ Phone#:_____

Language: _____Race:_____Nationality:_____

Family Doctor Name/Address:_____

_____ Phone#:_____

Referred By: _____

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Pharmacy:_____Phone#:_____Fax#:_____

Chief complaint/problem:_____

Employer: _____Occupation:_____

Employer Address and Phone#: _____

Primary Insurance: _____Eff Date: _____

Id#: _____Phone#:_____

Subscriber Name: _____Date of birth: _____

Secondary Insurance: _____Eff Date: _____Phone#: _____

Subscriber Name: _____Date of Birth:_____

Id#: _____Phone#: _____

Signature: _____Today's Date: _____

Patient Account # (_____ --- _____) ☐ New ☐ Established

Today's Date: ___/___/___

Advanced Orthopaedic Centers

Patient Medical History

Please Print Clearly

Patient Name: last: _____, first: _____ int: _____

Sex: ☐M ☐F Ht: ___'____" Wt: ____ lbs DOB: ___/___/___ Age: ____ yrs

Chief Complaint: _____

How and where did your injury occur? _____

_____

Date of Accident or onset of symptoms: ___/___/___ ☐ right handed ☐ left handed

Family Doctor: _____ Referred by: _____

Has patient or family ever been treated for:

Patient	Family		Patient	Family	
☐	☐	heart problems	☐	☐	liver problems
☐	☐	kidney/bladder problems	☐	☐	lung problems
☐	☐	stroke	☐	☐	high blood pressure
☐	☐	diabetes	☐	☐	cancer
☐	☐	TB	☐	☐	arthritis or gout
☐	☐	seize disorder	☐	☐	allergies: _____

Has patient ever experienced difficulty with:

☐	skin disorders	☐	ear/nose/throat	☐	headaches
☐	dental/gum problems	☐	chest pain	☐	bruising easily
☐	dizziness	☐	constipation	☐	diarrhea
☐	chronic indigestion	☐	rectal bleeding	☐	swollen joints
☐	nausea/vomiting	☐	urinary problems	☐	mental problems
☐	other medical problems	☐	trouble breathing	☐	substance abuse

Please specify: _____

List Current Medications: _____

Dates and descriptions of surgeries and/or hospital admissions:

___/___/___ _____

___/___/___ _____

Patient's Occupation: _____

Social History; alcohol: ☐ daily ☐ weekly tobacco: ☐ daily ☐ weekly

Other activities: _____

X-rays: ☐ YES or ☐ NO if yes, where: _____, date ___/___/___

THOMAS P. OBADE, MD | BOARD CERTIFIED | FACS | AANA
BRUCE A. MONAGHAN, MD | BOARD CERTIFIED | HAND SURGEON
STEVEN FREY, MD | SPORTS MEDICINE
NATHAN T. HOLMES, MD | BOARD CERTIFIED | ABFM SPORTS MEDICINE

Patient's Name: _____
Last First Initial

CONSENT TO TREATMENT

I consent to medical treatment for the above named patient as necessary or appropriate including but not restricted to whatever drugs, physical examination and office treatment, laboratory, x-ray, or other studies that may be used by Dr. Thomas P. Obade, Dr. Bruce A. Monaghan, Dr. Steven Frey, Dr. Dathan T. Holmes or their employees as appropriate. I recognize that any proposed operative procedures or invasive diagnostic tests will be explained to me and that I will be asked to specifically consent to them in advance (except in an emergency).

PAYMENT ASSIGNMENT OF INSURANCE BENEFITS

I take full responsibility for payment of such services. I agree to pay for such services in full, AT THE TIME SERVICE IS PROVIDED, unless other arrangement are made in advance with the Billing Department.

I hereby authorize direct payment to Orthopaedics at Woodbury of any insurance benefits and/or automobile personal injury protection benefits to which I may be entitled.

I also agree to be personally responsible for all charges not paid by third party payers to Orthopaedics at Woodbury.

RELEASE OF MEDICAL RECORDS/INFORMATION

I hereby authorize Orthopaedics at Woodbury to release any information regarding my medical history, treatment, disability and/or other information known to Orthopaedics at Woodbury concerning the above named patient to the responsible insurance company, the patients, employer and/or their attorney.

I also acknowledge that the information I have provided is accurate and complete to the best of my knowledge.

_____ _____/_____/_____
Patient's Signature/Guardian (If Minor) Date

_____
Witness

HIPAA Notice of Privacy practices

Patient Acknowledgment

We are required by law to maintain the privacy of protected health information, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPAA Compliance Officer in person or by phone at our main phone number

Signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review this Notice of our Privacy practices:

Print Name: _____

Signature: _____

Date: _____

Authorization to Leave Voicemail Messages

I give permission to Advanced Orthopaedic Centers to leave messages on my home answering machine or my cell phone. I understand that I may revoke this authorization at any time by contacting Advanced Orthopaedic Centers in writing. I understand that I am not required to sign this authorization.

Home Telephone: _____

Cell Phone: _____

_____

Patient Signature

Authorization to Communicate with Family/Friends

In addition to speaking with me, you may discuss my care, treatment, test results and billing issues with the following family members and/or friends. I understand that I may revoke this authorization at any time by contacting Advanced Orthopaedic Centers in writing. I understand that I am not required to sign this authorization.

Name	Relationship	Telephone
_____	_____	_____
_____	_____	_____

_____

Patient Signature