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: ___________
_____	_____	high cholesterol	_____	_____	color blindness

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 ___/___/___

EMG : YES or NO if yes, where: _______________________________, date ___/___/___

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

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. Nathan 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