Galloping Hill ORTHOPEDICS

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PATIENT INFORMATION SHEET – ***PLEASE PRINT*** **DATE:** _____

Mr/Mrs/Ms/Miss _____

Last Name **First Name** **MI**

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth :_____ Age: _____ Sex: _____ Social Security #: _____- _____- _____

Home Telephone #: _____ Cell#:_____ Marital Status: S M D W

EMAIL: _____ Working Status: __Working __Not Working __Retired __ Disabled

Pharmacy Name: _____ **Phone #:** _____

Address_____

****

GOVERNMENT MANDATED QUESTIONS:

Race: __ White __ Black/African American __ American Indian/Alaska Native

__ Native Hawaiian/Other Pacific Islander __ Other __ Decline to Answer

Ethnicity: __ Spanish/Hispanic Origin __ Not of Hispanic Origin __ Patient Declined/Unknown

Primary Language: _____ **Country:** _____

Secondary Language _____ **Country**: _____

****

Referring/Primary Physician:_____

Name (this must be filled out) AND Address

Phone # _____

Employer: _____ **Occupation:**_____

Address: _____ City: _____ Zip: _____

Work Telephone #: _____

Parent/Spouse's Name: _____ Parent/Spouse's Date of Birth: _____

Parent/Spouse's Employer _____Telephone #: _____

Address: _____ City: _____ Zip: _____

INSURANCE INFORMATION: **ID#** _____

Primary Insurance Carrier: _____**Subscriber**: _____

Relationship: _____ **Subscriber DOB:** _____

Secondary Insurance Carrier: _____ **Subscriber**: _____

Relationship: _____ **Subscriber DOB:** _____

Patient Name: _____**Reviewed By:** _____ **Date:** _____

(PLEASE CIRCLE OR MARK AN "X" FOR ALL ANSWERS LISTED BELOW)

When did your pain first start? _____

How did your pain start? _____

Does the pain radiate from this part of your body to another area? No Yes If yes, where? _____

What part of the body are you seeing the doctor for today? _____

Was it the result of an accident or injury? Yes No ( ) car accident ( ) work accident *( ) other accident

If "other" please explain what type of accident & where it happened _____

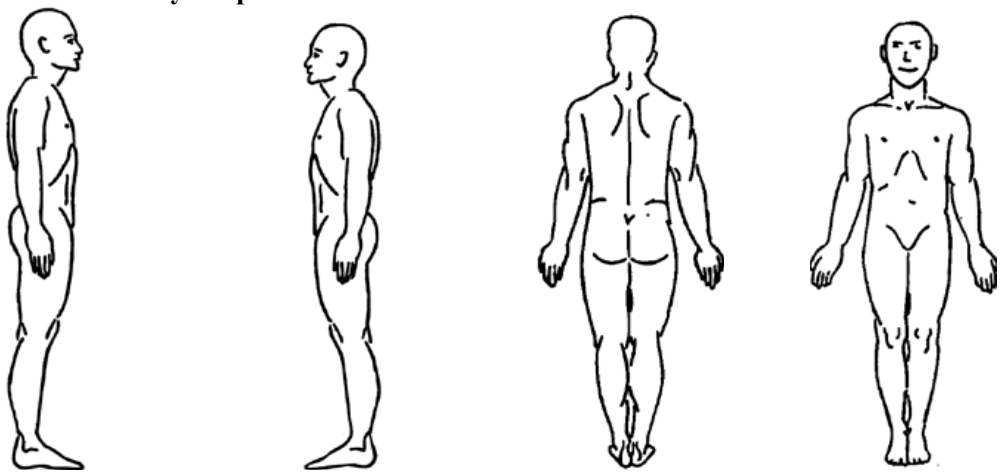
_____

Date of Accident/Injury: _____ **Are you involved in litigation (a lawsuit)?** Yes No

Please circle the words that best describe your pain:

ACHING HOT SHOOTING SHARP COLD BURNING NUMB SEVERE STABBING TINGLING

Please indicate where your pain is:



On a scale of 1-10 with 1 being no pain and 10 being the worst possible pain, please circle your pain scale right now:
1 2 3 4 5 6 7 8 9 10
On a scale of 1-10 with 1 being no pain and 10 being the worst possible pain, please circle the most pain you have been in over the past two weeks:
1 2 3 4 5 6 7 8 9 10
Please circle if your pain is:

Constant Intermittent Brought on by Aggravating Factors: walking sitting climbing stairs other: _____

Is there a time of day when your pain is usually better or worse? Better? AM / PM Worse? AM / PM

What makes the pain better? _____

What kind of treatment have you had for pain: Chiropractor Injections Physical Therapy Surgery Acupuncture

Medication Tens Unit Other _____ **How long did you have the treatment?** _____

Do you use an assistive device to get you around: Cane Walker Wheelchair Scooter

HEIGHT: _____ **WEIGHT:** _____ **BLOOD PRESSURE:** _____

Exercise: __ none __ rare __ regular __ occasional **W**hat type? _____

History of substance abuse N Y **S**moke N Y **P**reviously smoked N Y **D**o you live alone N Y

Drink alcohol: __Occasionally __ Rarely **S**pecial diet N Y **Do you wear dentures** N Y

ALLERGIES: Medication Allergies:_____

Non Medication Allergies: _____

Please check which, if any, apply to you: **No known drug allergies ___** **No known other allergies ___**

REVIEW OF SYSTEMS: Do you have problems with any of the following?

Eyes	No	Yes	Bleeding Problems	No	Yes	Blackouts/Fainting	No	Yes
Ears, Nose, Throat	No	Yes	Balance Problems	No	Yes	Psychological Problem	No	Yes
Thyroid	No	Yes	Numbness/Tingling	No	Yes	Bowel Movement	No	Yes
Heart Palpatations	No	Yes	Currently Pregnant	No	Yes	Bladder Problems	No	Yes
Shortness of Breath	No	Yes	Headaches/Dizziness	No	Yes	Chest Pain	No	Yes
Blurred Vision	No	Yes	Hearing Changes	No	Yes	Weakness	No	Yes
Swelling of Ankles	No	Yes	Swelling of other joints	No	Yes	Incontinence	No	Yes
Chronic Cough	No	Yes	Constipation	No	Yes	Sleep Problems	No	Yes

HISTORY PRESENT ILLNESSES: Do you currently have the following conditions?

Arthritis	No	Yes	Epilepsy	No	Yes	Ulcers	No	Yes
Digestion	No	Yes	Cancer	No	Yes	Tuberculosis	No	Yes
Asthma	No	Yes	Hepatitis	No	Yes	COPD	No	Yes
Polio	No	Yes	High Cholesterol	No	Yes	HIV positive	No	Yes
AIDS	No	Yes	Rheumatoid Arthritis	No	Yes	Anxiety/Depression	No	Yes

*Heart Surgery No Yes *If yes, did you have a pacemaker or valve replacement _____

**Diabetes No Yes *If diabetic do you take insulin? No Yes

***High Blood Pressure No Yes ***Is your high blood pressure controlled with medication No Yes

Do you have a Family History of cancer, heart disease, diabetes, etc. _____

Describe ALL YES Responses: _____

_____

What Medications do you take for health problems, pain, including antibiotics, aspirin products and supplements?

_____

_____

_____

Have you had any testing for this condition. If so when was the last date? EKG _____ Chest X-ray _____

Blood work _____MRI _____ Xray _____ EMG _____Cat Scan _____

Name of hospital/ lab/ doctor's office where tests were performed: _____

Have you had any type of Surgery or Hospitalizations: If so what kind of surgery _____

Name of hospital _____

Have you ever had general anesthesia? N Y Did you have problems? If so please describe :

Date	Reason for Hospitalization	Complications

PLEASE ANSWER ALL QUESTIONS REGARDING YOUR PRIVACY INFORMATION

We need this information to comply with federal regulations

	Appointment Information		Medical Information	
On home phone (including auto call)	**___N**	**___Y**	**___N**	**___Y**
On cell phone (including auto call)	**___N**	**___Y**	**___N**	**___Y**
On your office Voice Mail	**___N**	**___Y**	**___N**	**___Y**
With another person	**___N**	**___Y**	**___N**	**___Y**
Send via Mail	**___N**	**___Y**	**___N**	**___Y**
Send via Email	**___N**	**___Y**	**___N**	**___Y**
Send via *Fax (*Must be private fax)	**___N**	**___Y**	**___N**	**___Y**

***Our office will not be responsible for HIPAA violation of any kind if you have answered YES to any of the above questions**

If you answered YES to allowing us to discuss your appointment and/or medical information with another person, please list their name(s) and phone numbers below:

NAME RELATIONSHIP PHONE # CELL PHONE

_____

_____

_____

ADDITIONAL HIPAA CONTACT INSTRUCTION:

_____

_____

_____ _____

*PATIENT SIGNATURE DATE SIGNED

*BY AFFIXING MY SIGNATURE, I HAVE READ AND UNDERSTAND THE HIPAA QUESTIONS & ANSWERS ABOVE. I ALSO CONFIRM THAT MY ANSWERS TO THE PREVIOUS HEALTH QUESTIONS ARE CORRECT; AND, THAT I HAVE NOT ELIMINATED ANY INFORMATION FROM THE PROVIDERS OF THIS PRACTICE.

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ASSIGNMENT OF BENEFITS

PATIENT NAME: _____

I irrevocably assign payment to Galloping Hill Orthopedics from any and all insurances that I have for services rendered to me. I also waive any and all rights and benefits that were put into place by my insurance carrier as applies to payment benefits. I am aware that ultimately I am responsible for payment of services rendered to me that is not covered by my insurance plan (to include denials to this Practice due to my failure to obtain a referral or if I am remiss in answering any questionnaire sent to me by my insurance carrier). This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

-I IRREVOCABLY AUTHORIZE ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO ANY CLAIMS BY GALLOPING HIL ORTHOPEDICS TO BE RELEASED TO GALLOPING HIL ORTHOPEDICS.

-I IRREVOCABLY AUTHORIZE GALLOPING HIL ORTHOPEDICS TO FILE INSURANCE CLAIMS ON MY BEHALF FOR SERVICES RENDERED TO ME.

-I IRREVOCABLY DIRECT THAT ALL SUCH PAYMENTS GO DIRECTLY TO GALLOPING HIL ORTHOPEDICS.

-I IRREVOCABLY AUTHORIZE GALLOPING HIL ORTHOPEDICS TO ACT IN MY BEHALF AND REPORT ANY SUSPECTED VIOLATIONS OF PROPER CLAIMS PRACTICES TO THE PROPER REGULATORY AUTHORITIES.

PATIENT SIGNATURE: _____**DATE:** _____

COORDINATION OF BENEFIT FORM

Dear Patient – Your insurance contract provides for benefits to be coordinated with other medical insurance by which you may be covered. Your primary carrier pays first when there is more than one insurance company or health care provider.

Patient ID# _____ **Group Name & #** _____

Patient's name _____ **Subscriber's name** _____

Full name of spouse _____ **Spouse SS#** _____

Spouse's employer: _____ **Spouse DOB:** _____

Is your spouse covered by any health insurance? Y N Name of carrier _____ **ID#** _____

Is your problem covered by any other insurance Y N Name of carrier _____**ID#** _____

To the best of my knowledge the statements above are accurate and complete. Unanswered questions indicate they do

not apply. My signature authorizes insurance carrier, any & all information concerning claims filed by me or on my behalf to another insurance carrier.

***Patient Signature** _____ **Date** _____

***Please note that if your insurance contract contains a pre-existing health clause, they may not pay for the services performed by our office. If payment for services is denied by the insurance carrier, you will be responsible for payment. If our claim is held up for payment by your carrier for investigation of a pre-existing condition for longer than 90 days, you will be responsible for payment of the entire bill. By your signature, you have read our protocol for pre-existing condition clauses.**

PATIENT LIABILITY AGREEMENT

I understand that I am financially responsible for all bills incurred while under the care of Associated Orthopaedics. In the event that my account is not paid in full, I shall be liable for any and all costs of collections, including, but not limited to an additional 35% fee* (*as defined by the balance of the bill due divided by .65) of the outstanding balance if my account is forwarded to a collection agency for collection; and, if my account is forwarded to any attorney for legal proceedings. I agree to be liable for an additional attorney fee of 50% of the outstanding balance. I also understand that I need to give the Providers of this Practice at least 24 hours notice if I can't make my office appointment. If I fail to do this, I will be responsible to pay $50 for the office visit, $100 for an EMG appointment. I also am being notified that if I do not give at least 48hrs notice for cancelling a surgical procedure, I will be responsible to pay a fee of $300.00. By signing below, I hereby indicate that I have read this agreement, understand the terms of this agreement and agree to the terms of this agreement.

Patient/Guardian (Print Clearly)

_____

Patient/Guardian Signature

_____

Date Signed _____