East Alabama Orthopaedics & Sports Medicine Patient Info Sheets

Patient ID **Appointment:** EAOSM-Main
Other ID

Patient Name: **DOB:** **SSN:**
Preferred Name: **Patient Religion:** _____
Patient Address: **Patient Race:** _____
Patient Ethnicity: Hispanic or Non-Hispanic
Please circle one

Home: **Cell:** **Work:**

Email: _____

Preferred Pharmacy: _____ **City:**_____

Primary Care Provider: _____ **Referral:** _____

Patient's last appointment:

Emergency Contact Name and Number: _____

Person Financially Responsible for charges:

Primary Insurance: ***No Primary Plan***
Policy Number: **Grp:**
Policy Holder: **DOB:** _____ *If not Pt.

Secondary Insurance: ***No Secondary Plan***
Policy Number: **Grp:**
Policy Holder: **DOB:** _____ *If not Pt.

I authorize all East Alabama Orthopaedics & Sports Medicine Physicians and/or whomsoever he/she may designate as his/her professional representative/assistant to discuss any aspect of my orthopaedic care, to include: appointments, tests, test results, surgical procedures, prescriptions, and any other pertinent information pertaining to my care with the following designated people. (if no one, leave blank)

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

This document will be a part of your permanent record. In the event that any of the selected representatives that you have designated change, it will be necessary to update our records with a written notification.

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Authorization for Medical and Diagnostic Treatments

(1) I wish to receive treatment at East Alabama Orthopaedics and Sports Medicine (EAOSM). While I am at EAOSM, I permit my doctor, EAOSM, and its employees, and all other persons caring for me to treat me in ways they judge are beneficial to me. (2) EAOSM sometimes serves as a training center for students in a variety of different health care professions. Students will sometimes be allowed to observe procedures which would benefit their educational experience. I do not object to students observing my care, treatment or procedures performed upon me. (3) I understand that medical equipment/supply company representatives will sometimes be present during a procedure to instruct medical personnel on new equipment or supplies. I do not object to these representatives being present during my care, treatment, or procedures performed upon me. (4) I understand that photographs or films may be taken during the course of my treatment to be made a part of my medical record. I do not object to the taking of these photographs or films.

Release of Medical Information

I, the undersigned as the patient or his/her authorized representative, authorize EAOSM and any other professionals who provided care, treatment or services to release to my insurance company (ies) or their authorized representative or other appropriate agency (ies) that information which is necessary to validate this claim for payment purposes. This includes my employer if workers' compensation is claimed. EAOSM is also authorized to release to my physician(s), or the persons authorized to bill for them, such information as necessary for billing purposes, including, without limitation, all records and information pertaining to my medical treatment (including that for drug & alcohol abuse), laboratory & other diagnostic tests results, x-rays, therapy, diagnoses and prognosis. In the event that I am transferred to another healthcare facility, I authorize EAOSM to make a copy of my medical records for the receiving healthcare facility.

Release of Responsibility for Loss of Valuables

I understand that EAOSM will not be responsible for valuables, including jewelry, watches, money, etc., not specifically placed in the care of EAOSM through proper procedures. I also understand that EAOSM cannot be responsible for personal items such as clothing, glasses, dentures, etc., inadvertently damaged or misplaced during my course of treatment. I accept full responsibility for those valuables or personal items which I choose to keep in my possession.

Medicare and/or Medicaid Patient's Certification

I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release such information to the Social Security Administration of the State of Alabama or any of their intermediaries or carriers for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made to EAOSM and/or other physicians involved in my care on my behalf.

Patient's Signature: _____ **Date:** _____

Or Authorized Representative **Authorized Representative: Relationship:** _____

If the patient or their authorized representative is unable to sign, state the reason why here: _____

Assignment of Insurance and Financial Responsibility

I authorize payment of all insurance benefits, basic and major medical, for this period of medical, emergency and/or diagnostic treatments, to be made directly to EAOSM. I understand that I am financially responsible for all charges not covered by my insurance plan, including but not limited to co-pays, deductibles, non-covered charges, professional fees and nurse practitioner professional fees. All efforts for collection of the benefits are for my convenience and do not represent a guarantee for collection or a credit to my account until such time as payment is received by EAOSM. I also assign the benefits payable for physicians' services to the physicians(s) furnishing the services, or authorize such physicians or physician group to submit a claim to my insurance company (ies), Medicare and/or Medicaid. I will be responsible for any collection fees, court cost and/or attorney fees incurred by EAOSM or any physician participating in my care while collecting on my account(s). Photocopies of this authorization are as valid as the original. I authorize EAOSM, its employees and agents to contact me at any/all phone numbers (including cell phone numbers) for the purpose of treatment, insurance and payment. I acknowledge that I may be contacted by telephone at any telephone number associated with my account including wireless telephone numbers, which could result in charges to me. I also may be contacted by text messages or emails, using any email address that is provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices. By my admission to EAOSM, I acknowledge that I am entering into a credit transaction as defined under The Fair Credit Reporting Act 15 U.S.C.§ 1681and that EAOSM may, with or without my knowledge, obtain a consumer credit report for all permissible purposes, including, but not limited to, debt collection activities and use the information in connection with a determination of the consumer's eligibility for a license or other benefit granted by a governmental instrumentality required by law to consider an applicant's financial responsibility or status.

Patient's Signature: _____ **Date:** _____

Or Authorized Representative **Authorized Representative: Relationship:** _____

If the patient or their authorized representative is unable to sign, state the reason why here: _____

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Medical History Questionnaire

Patient Name: **Patient DOB:** **Age:** **Sex:** Unknowr

Height:_____ Weight: _____ *For Office Use: BP:_____ Pulse:_____*

Who referred you for this visit; if not referred, please indicate _____

Reason for seeing Doctor: _____ Injury? Yes or No

Worker's Comp _____ Auto Accident _____ Sports _____ Date of Injury/Onset_____

Past Medical History

Do you have, or have you had, any of the following: (PLEASE CIRCLE)

Diabetes High Blood Pressure Heart Condition High Cholesterol Pacemaker Seizure Blood/Bleeding Disorder

Phlebitis/Blood Clots Stroke Asthma Emphysema Sleep Apnea Complications of Anesthesia Cancer Ulcer

List any other medical conditions and/or illnesses not mentioned above: _____

_____

List reasons for hospitalizations and/or surgeries with dates and any complications_____

_____

Are you currently taking any medications? YES / NO Are you taking any blood thinner medications? YES / NO

List all current medications_____

_____

Do you have ANY drug allergies? YES / NO List allergies:_____**Latex Allergy? YES / NO**

_____

Family History (If deceased, please provide age and cause)

Age(s) and overall health of parents _____

Age(s) and overall health of sibling(s) _____

List any significant family health problems _____

Social History

Marital Status _____ Education (years/degree)_____

Alcohol Use: YES / NO (type/amount)_____ Tobacco Use: YES / NO (amount/years used)_____

Employer _____ Occupation _____

Review of systems *(Circle positive symptoms and describe and/or add others, if needed)*

Constitutional: Fever, weight gain/loss, loss of appetite

Eyes: Double vision, blurring, difficulty seeing

ENT: Deafness, sinusitis, hoarseness, vertigo

Cardiovascular Chest pain, murmur palpitations, irregular/rapid heartbeat

Respiratory: Shortness of breath, wheezing, spitting blood, chronic cough

Digestive: Abdominal pain, constipation, diarrhea, bleeding

Urologic: Pain when urinating, hesitancy, bleeding, incontinence

Skin: Rashes, lesions that do not heal, changes in moles

Gynecologic: Breast masses, pain, discharge, problems

Neurologic: Seizures, loss of balance/coordination, paralysis, weakness, loss of memory

Psychiatric: Depression, anxiety, hallucinations, sleep disturbances

Endocrine: Excessive thirst, excessive urination, heat/cold intolerance

Blood and Lymph: Anemia, bleeding tendencies, swollen nodes

Allergy/Immunologic: Hives, Eczema, Itching

Musculoskeletal: Stiffness, joint pain/deformity, muscle wasting, spine pain radiating to arm/leg

OTHER: _____

_____

_____ _____ _____ _____

Patient Signature ***Date*** *Physician Signature* *Date*

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HIPAA NOTICE OF PRIVACY

By signing below, I hereby acknowledge the receipt, or offer of receipt, of the privacy notice:

Printed Name of Patient	**Date**
Signature of Patient/Representative	**Date**

To be completed by East Alabama Orthopaedic & Sports Medicine:

After a good faith attempt was made to obtain an Acknowledgment of Receipt, the patient / representative was unable to sign the Privacy Notice for the following reason(s): _____

_____

Signature of Facility Representative	**Date**