

SOUTHWEST ORTHOPEDIC GROUP, LLP

DATE: _____

DR. NAME: _____

PATIENT DATA

Last Name _____ First Name _____ Middle _____ SOCIAL SECURITY NO: _____
Date of Birth _____ Age _____ MALE OR FEMALE _____ Marital Status: M S W D
Home Address _____ Apt. No. _____ HOME PHONE: _____
City _____ State _____ Zip Code _____ WORK PHONE: _____
Occupation: _____ CELL PHONE: _____
Referred By: _____ OFFICE NO.: _____

EMERGENCY CONTACT INFORMATION:

NAME _____ PHONE NO.: _____ RELATIONSHIP: _____

EMPLOYER INFORMATION:

EMPLOYER NAME _____ PHONE NO.: _____
Address _____ City _____ State _____ Zip Code _____

GUARANTORS INFORMATION:

Last Name _____ First Name _____ Middle _____ Social Security Number _____ Date of Birth _____
Patient's Relationship to Policy Holder: _____ HOME PHONE: _____
Home Address _____ Apt. No. _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Name of Primary Insurance _____ Customer Service No: _____
ID NUMBER _____ GROUP NO. _____

SECONDARY INSURANCE:

Name of Secondary Insurance _____ Customer Service No: _____
ID NUMBER _____ GROUP NO. _____

AUTHORIZATION TO PAY BENEFITS OF PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT RELEASE ME FROM MY PERSONAL RESPONSIBILITY FOR PAYMENT OF ALL CHARGES WITHIN 50 DAYS. AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

SIGNATURE _____

DATE _____

GERARD T. GABEL, M.D.
HAND, SHOULDER AND ELBOW SURGEON

Department of Orthopedic Surgery

(PLEASE FILL OUT COMPLETELY INCLUDING BACK SIDE OF THIS SHEET)

DATE _____ NAME _____

AGE ___ REFERRED BY _____

Employer _____ Job Title: _____

Marital Status S M D W

ARE YOU: Right handed _____ Left handed _____

Where is the Pain: NECK PAIN ___

RIGHT: Shoulder ___ Elbow ___ Forearm ___ Wrist ___ Hand ___ Finger ___

LEFT: Shoulder ___ Elbow ___ Forearm ___ Wrist ___ Hand ___ Finger ___

When did your symptoms begin? ___/___/___ What are your symptoms?

If your symptoms are the result of an injury, where and on what date did the accident occur? Where: home ___ school ___ work ___ auto ___ Date ___/___/___

What happened? _____

If work related, how long have you worked at this job? _____

Any history of other job related injury? _____

Describe: _____

If job related, date last worked? _____ Present work restrictions: _____

Is there an Attorney involved Yes No
Name _____ Phone (____) _____

What treatment(s) have you had for this problem (i.e. injections, medication, surgery, therapy, splints, ect)? _____

What tests have been performed? (Please include: X-ray, EMG's, CT scan, MRI, arthrogram and blood tests) _____

PATIENT HISTORY

PAST MEDICAL HISTORY

	You	Family Member		You	Family Member
Diabetes:	___	___	Lung Problems:	___	___
Heart Problems:	___	___	Transfusion:	___	___
Rheumatoid Arthritis:	___	___	Lupus:	___	___
Thyroid Problems:	___	___	Tuberculosis:	___	___
Asthma:	___	___	Hiatal Hernia:	___	___
Blood Clots:	___	___	Psych Problems:	___	___
Cancer:	___	___	Irregular Heart:	___	___
Pneumonia:	___	___	Colitis:	___	___
Bleeding Problems:	___	___	Alcohol Abuse:	___	___
			High Blood Pressure:	___	___
			Hepatitis:	___	___
				__A__	__B__C
Kidney Problems:	___	___	HIV	___	___

Last Menstrual Period: _____ Pregnant? Yes No

Do you smoke? Yes No If yes, how many pack(s) per day?

Do you have any hobbies that involve the use of your hand(s) or arm(s)?
Yes___No___ If yes, what are they?_____

Do you have pain in any other joints? If yes, which joints? _____

Please list all medication(s) to which you have had an allergic or bad reaction:

Please list all medication(s) you are currently taking (including non-prescriptions medications): _____

Please list any surgeries: _____

SOUTHWEST ORTHOPEDIC GROUP, LLP

Review of Notice of Privacy Practices

Acknowledgement:

I acknowledge that I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

**Patient or Personal Representative
Signature**

Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____.

Financial Policy Statement

It is the policy of Southwest Orthopedic Group, L.L.P. to bill your insurance carrier as a courtesy to you; however, you are responsible for the entire bill. We require that arrangements for payment of your estimated share be made today. The insured/patient is responsible for any co-payments at the time service is rendered. If your insurance carrier does not remit payment within sixty (60) days, the balance will be due in full from you. If your insurance pays in excess of the balance of your account, we will refund the credit.

If any payment is made directly to you for services billed by Southwest Orthopedic Group, L.L.P., you recognize an obligation to promptly remit same to Southwest Orthopedic Group, L.L.P.

The above does not apply for those patients that are considered Workers' Compensation. However, be advised as a Compensation patient that you may be held responsible for your charges in the event that your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Southwest Orthopedic Group, L.L.P., I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

Patient or Responsible Party

Date