

**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 \_\_\_\_\_

**JEFFREY E. BUDOFF, M.D.**

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex M F

I am: Right-Handed Left-Handed Injured Arm: Right Left

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Major Hobbies \_\_\_\_\_

Referring Physician and **Phone Number** \_\_\_\_\_

Date of Injury \_\_\_\_\_

Reason for Your Visit Today \_\_\_\_\_

**PMH:** Please Circle Any of the Following Conditions That You **CURRENTLY** Have:

Insulin Dependent Diabetes                      High Blood Pressure                      Heart Disease

Non-Insulin Dependent Diabetes                      Blood Clots                      Heart Attacks

Hypothyroidism/Hyperthyroidism                      Bleeding Disorder                      Lung Disease

Reaction to Anesthesia                      Kidney Disease                      Hepatitis

HIV/AIDS                      Peptic Ulcer Disease                      Liver Disease

Rheumatoid Arthritis                      Drug Abuse                      Alcoholism

Asthma                      Psychiatric Disorder: What type? \_\_\_\_\_

Cancer: What Type? \_\_\_\_\_ Are You Pregnant: Y N

Any Other Medical Problems? \_\_\_\_\_

**PSH:** Please List Each Surgery (Procedure and Date) That You Have Had:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** Please List Any MEDICATIONS That You Are Allergic to and What Happens When You Take Them:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications:** Please List ALL Medications You Take. Including Aspirin, Motrin, etc:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# ***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