SOUTHWEST ORTHOPEDIC GROUP, LLP

DATE: ______________________ **DR. NAME:** ________________________

PATIENT DATA

____ SOCIAL SECURITY NO: _________________
Last Name First Name Middle

____________________ _______ MALE OR FEMALE **Marital Status**: M S W D
Date of Birth Age

____ HOME PHONE: _________________________
Home Address Apt. No.

_______________________ ________ ___________ WORK PHONE: ________________________
City State Zip Code

CELL PHONE: _________________________

Occupation: ______________________________

Referred By:____ OFFICE NO.: ___________________________

EMERGENCY CONTACT INFORMATION:

__________________________________ PHONE NO.: __________________ RELATIONSHIP: _________________
NAME

EMPLOYER INFORMATION:

____ PHONE NO.: ______________________
EMPLOYER NAME

____ _________________________________
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:

____ Customer Service No: ______________________
Name of Primary Insurance

_____________________________________ _______________________
ID NUMBER GROUP NO.

SECONDARY INSURANCE:

____ Customer Service No: ______________________
Name of Secondary Insurance

____________________________________ _______________________
ID NUMBER GROUP NO.

AUTHORIZATION TO PAY BENEFITS OT PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY OTHERWISE PAYALE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT RELEASE ME FROM MY PERSONAL RESPOBSIBILITY 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, MD

(Nombre) ***(Fecha de hoy)***
Patient Name________________________________ Today's Date_____________

(Edad) ***(Fecha de Nacimiento)***
Age____________ Birthdate_______________ Sex: M F

(Mano Dominante) Derecha / Izquierda ***(Brazo Lastimado) Derecha / Izquierda***
I am: Right-Handed Left-Handed Injured Arm: Right Left

(Ocupacion) ***(Empleado)***
Occupation__________________________________ Employer____________________

Major Hobbies____

(Doctor que lo referio)
Referring Physician and **Phone Number** ______________________________________

(Fecha que se lastimo)
Date of Injury_________________________

(Racon por su visita de hoy)
Reason for Your Visit Today____
____

(Circule las condiciones que tenga o que a tenido)
PMH: Please Circle Any of the Following Conditions That You Have or Have Had:

(Diabetes-dependiente de insulina) ***(Alta Prescion)*** ***(Enfermedad de corazon)***
Insulin Dependent Diabetes High Blood Pressure Heart Disease

(Diabetes-no depende en la insulina) ***(Clotos de sangre)*** ***(Atace de corazon)***
Non-Insulin Dependent Diabetes Blood Clots Heart Attacks

(Hipotiroidismo) ***(Desorden de la sangre)*** ***(Enfermedad de pulmones)***
Hypothyroidism Bleeding Disorder Lung Disease

(Reaccion de anestesia) ***(Enfermedad de rinones)*** ***(Hepatitis)***
Reaction to Anesthesia Kidney Disease Hepatitis

(SIDA) ***(Ulcera Peptica)*** ***(Enfermedad del igado)***
HIV/AIDS Peptic Ulcer Disease Liver Disease

(Reumatoide Artritis) ***(Abuso de drogas)*** ***(Alcoholismo)***
Rheumatoid Arthritis Drug Abuse Alchoholism

(Asma) ***(Desorden siquiatrico) Que tipo?***
Asthma Psychiatric Disorder: What type?_______________

(Cancer) Que tipo? *Esta embarazada? Si / No*
Cancer: What Type?______________________________ Are You Pregnant: Y N

(Otros problemas medicos?)
Any Other Medical Problems?____

(Liste cada operacion que a tenido y en que fecha lo tuvo)
PSH: Please List Each Surgery (Procedure and Date) That You Have Had:
____
____
____

(Alergias:) Por favor de listar las medicinas que tiene alergias. Que reaccion tiene?
Allergies: Please List Any MEDICATIONS That You Are Allergic To, and What Happens When You Take Them:
____
____
____

(Medicinas:) Cuales medicinas esta tomando? Incluyendo Aspirina y Motrin
Medications: Please List ALL Medications You Take, Including Aspirin, Motrin, etc:
____
____
____

(Symtomas) ***(Por favor circule las siquientes enfermedades que tenga)***
Review of Systems: Please Circle Any of the Following that You Have:

(Fiebre)
Fever

(Mareo)
Dizziness

(Frio en las puntas de los dedos)
Fingertip Cold Intolerance

Rash

(Depresion)
Depression

(Ulcera en las puntas de los dedos)
Fingertip Ulcers

(Sangre en el escramento)
Blood in Stool

(Toz productiva)
Productive Cough

(Respiracion corta)
Shortness of Breath

(Picasoso o dormido en los piez)
Tingling or Numbness in Your Feet

(Dificil de horinar)
Difficulty Urinating

(Picasoso o dormido en la mano)
Tingling or Numbness in Your Hand

(Dolor en el pecho)
Chest Pain

(Dolor de los huesos) Acuales?
Joint Aches: Which Joints?______________________________

(Historia Social:)
Social History:

(Ud. Fuma?)	***Si / No***		***Cuanto?***
Do You Smoke?	Y	N	How Much?______________
(Ud. Toma?)	***Si / No***		***Cuanto?***
Do You Drink Alchohol	Y	N	How Much? _____________
(Usa drogas?)	***Si / No***		***Cuanto?***
Do You Use Recreational Drugs	Y	N	What Kind? _____________

Historia de Familia:Circule las siguientes problemas medicas en su mediate familia
Family History: Please Circle Any of the Following Medical Problems in Your
(Mediate Familia (Madre, Padre, Hermana, Hermano)
Immediate Family (Mother, Father, Sister, Brother):

(Reaccion de anestesia)	***(Alta prescion)***	***(Reumatoide Artritis)***
Reaction to Anesthesia	Hypertension	Rheumatoid Arthritis
(Problemas de Sangre)	***(Problemas del corazon)***	***(Diabetes)***
Bleeding Problems	Heart Problems	Diabetes
(SIDA)	***(Enfermedad del pulmon)***	***(Cancer) Que tipo?***
HIV/AIDS	Lung Disease	Cancer: What Type?_____________

(Otras enfermedades en la familia)
Other Diseases that Run in the Family:____

(Por favor de listar otra informacion que Ud. Siente que el doctor necesita saber)
Please List Any Other Information That You Feel the Doctor Needs to Know:
____
____
____

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**