

**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
Occupation: _____ CELL PHONE: _____
Referred By: _____ OFFICE NO.: _____

EMERGENCY CONTACT INFORMATION:

_____ PHONE NO.: _____ RELATIONSHIP: _____
NAME

EMPLOYER INFORMATION:

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

GUARANTORS INFORMATION:

_____ Social Security Number Date of Birth
Last Name First Name Middle
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 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

Any loss of bowel or bladder control? Yes No (Please explain)

Tingling? Yes No Right Left Both

Frequency of tingling Constant Intermittent

Location (Specify right/left/both as L/R/B below)

Buttock Thigh Calf Foot Toes

What makes pain better:

Nothing
 Medication
 Heat
 Ice
 Exercise
 Other _____

What makes pain worse:

Nothing Sitting
 Lifting Climbing Stairs
 Bending Coughing
 Stooping Sneezing
 Standing Riding in an mobile
 Walking

Review of systems

Do you know or have you had problems related to the following systems?

GU

Trouble with urination
 Frequent urination
 Blood in urine

NEURO/PSYCH

Headache
 Depression

ENT/PULMONARY

Sore throat
 Cough
 Trouble breathing
 Chest pain

OTHER

Fever °F
 Chills

GI

Abdominal pain
 Nause
 Vomiting
 Diarrhea
 Black/bloody stool

SKIN

Skin rash

Past Medical and Social History

Past medical history:

Peptic ulcer disease High blood pressure
 Heart disease Diabetes (Insulin, oral, diet)
 Compression fracture Cancer
 Intervertebral disc disease Prior back pain/injury
 Arthritis Sciatica
 Other _____

Previous Surgeries and dates:

None
 Back Laminectomy Fusion discectomy
 Other _____

Social History:

Smoker packs per day
 drugs
 Alcohol rarely occasionally heavy

Family History:

Recent physical therapy? Yes No

Frequency/duration: x per week for weeks/months Improvement with physical therapy:

Hot packs None Moderate
 Massage Some Very good
 Ultrasound
 Other _____

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