

**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 NO.: _____
Mailing Address Apt. No.
_____ CELL PHONE NO.: _____
City State Zip Code
BUSINESS PHONE: _____
Occupation: _____ E-MAIL ADDRESS: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ PHONE NO.: _____
RELATIONSHIP: _____

EMPLOYER INFORMATION:

_____ PHONE NO.: _____
Employer name
_____ City State Zip Code
Address

GUARANTOR/POLICY HOLDER INFORMATION:

_____ SOCIAL SECURITY NO: _____
Last Name First Name Middle
Date of Birth Patient's Relationship to Policy Holder: _____
_____ HOME PHONE NO.: _____
Home Address Apt. No.
_____ City State Zip Code

INSURANCE INFORMATION

PRIMARY INSURANCE:

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

SECONDARY INSURANCE:

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

AUTHORIZATION TO PAY BENEFITS TO 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 OF ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

SIGNATURE

DATE

Omer A. Ilahi, M.D.
Medical History Questionnaire

Please complete this form to help us identify factors that could cause or contribute to your current conditions, or that could affect your recovery. It is especially important to list all of your current medications and all medications which cause you to have an allergic reaction.

NAME: _____ DATE OF BIRTH: _____ OCCUPATION: _____

WHAT ARE YOU HERE TO SEE THE DOCTOR FOR?: _____

HAVE YOU HAD ANY X-RAYS OR IMAGING OF THE INJURED AREA? _____ WHERE? _____

IS THIS THE RESULT OF AN ACCIDENT? YES _____ NO _____ PERSONAL? _____ WORK RELATED? _____

WHO REFERRED YOU TO THIS OFFICE? _____

NAME OF FAMILY PHYSICIAN _____ DATE LAST SEEN? _____

HEIGHT _____ WEIGHT _____

MEDICATIONS **YOU** ARE CURRENTLY TAKING: _____

MEDICATION ALLERGIES: _____

PREVIOUS SURGERIES **YOU** HAVE UNDERGONE: _____

FAMILY HISTORY OF DISEASES/CONDITIONS: _____

Do **YOU**: SMOKE? NO: _____ YES: _____ PACKS PER DAY: _____
DRINK ALCOHOL? NO: _____ YES: _____ HOW OFTEN? _____

| Do YOU HAVE ANY PROBLEMS WITH: | CIRCLE | | DESCRIBE ALL YES RESPONSES. |
|---------------------------------------|--------|----|------------------------------------|
| ANESTHESIA | YES | NO | _____ |
| BLEEDING PROBLEMS | YES | NO | _____ |
| BLOOD CLOTS | YES | NO | _____ |
| CANCER | YES | NO | _____ |
| DIABETES | YES | NO | _____ |
| EPILEPSY / SEIZURES | YES | NO | _____ |
| EYES / VISION | YES | NO | _____ |
| HEART | YES | NO | _____ |
| HIGH BLOOD PRESSURE | YES | NO | _____ |
| LIVER / HEPATITIS | YES | NO | _____ |
| LUNGS / BREATHING | YES | NO | _____ |
| SLEEP APNEA | YES | NO | _____ |
| STOMACH ULCERS / DIGESTIVE | YES | NO | _____ |
| STROKE | YES | NO | _____ |
| THYROID | YES | NO | _____ |

OTHER MEDICAL PROBLEMS: _____

SIGNATURE: _____ DATE: _____

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