

**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

Southwest Orthopedic Group, LLP
Scott T. Orth, M.D.

****PLEASE FILL IN ALL BLANKS****

Patient Name: _____ Referred By: _____

SSN: _____ Date of Birth: _____ Age: _____ Marital Status: S M D W

Address: _____ Home #: _____

City: _____ State: _____ Work #: _____

Driver's License Number: _____ Cell #: _____

Employer's Name and Address: _____

Name of Spouse: _____ Phone #: _____

Spouse SSN# _____ Date of Birth: _____

In case of Emergency, please list an Emergency Contact:

Name: _____ Relation: _____ Phone # _____

Name: _____ Relation: _____ Phone # _____

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

DATE: _____ NAME: _____

COMPLAINTS OR PROBLEM: _____ INDICATE: LEFT: _____ RIGHT: _____

WHEN DID PROBLEM BEGIN? _____

REFERRED BY: _____ FAMILY DOCTOR'S NAME: _____

ARE YOU IN GENERAL GOOD HEALTH AT THIS TIME? YES _____ NO _____

EXPLAIN ALL OTHER MEDICAL PROBLEMS: _____

LIST ALL OPERATIONS OF ANY TYPE AND YEAR OF SURGERY: _____

HAVE YOU HAD PROBLEMS WITH ANESTHESIA, INFECTION, BLEEDING, OR OTHER SURGICAL COMPLICATIONS?

YES _____ NO _____ EXPLAIN: _____

HAVE YOU TAKEN MEDICINES FOR OR BEEN ON A DIET FOR: (CHECK YES OR NO)

	YES	NO		YES	NO		YES	NO
DIABETES	___	___	STOMACH ULCERS	___	___	NERVOUS CONDITION	___	___
HEART DISEASE	___	___	DIVERICULITIS	___	___	BLADDER DISEASE	___	___
KIDNEY DISEASE	___	___	SEIZURES	___	___	HIGH BLOOD PRESSURE	___	___
BLOOD THINNERS	___	___	ASTHMA/EMPHYSEMA	___	___	HORMONES/BIRTH CONTROL	___	___
ARTHRITIS	___	___	HEP/LIVER PROBLEMS	___	___	HIV/AIDS/RECURRENT INF.	___	___
THYROID DISEASE	___	___	GLAUCOMA	___	___	CANCER	___	___
CORTISONE	___	___						

LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING: _____

ARE YOU ALLERGIC TO ANY MEDICATION? YES ___ NO ___ IF SO CIRCLE OR LIST: PENICILLIN SULFA CODEINE
DEMEROL NOVOCAINE _____

HAVE YOU EVER BROKEN ANY BONES OR WORN A BRACE OR CAST? _____

IS THERE A HISTORY IN YOUR BLOOD RELATIVES OF (CIRCLE): HEART DISEASE CANCER ABNORMAL BLEEDING
CONGENITAL DISORDERS MUSCLE DISEASE LUPUS RHEUMATOID ARTHRITIS OTHER FAMILY DISORDERS _____

ARE YOUR PARENTS LIVING? MOTHER YES ___ NO ___ DIED AT AGE ___ OF _____
FATHER YES ___ NO ___ DIED AT AGE ___ OF _____

DO YOU USE/SMOKE TOBACCO? YES ___ NO ___ HOW MUCH? ___ (PACKS PER DAY) FOR ___ YEARS.

PLEASE ESTIMATE YOUR ALCOHOL CONSUMPTION (CIRCLE): DON'T USE LIGHT OCCASIONAL/SOCIAL
MODERATE HEAVY OVERUSE

SHOULDER SHEET

RIGHT

LEFT

RIGHT HANDED

LEFT HANDED

DATE: _____ NAME: _____

AGE: _____ WEIGHT: _____ MALE FEMALE

Do you have any other joint pain? YES NO If Yes, Where: _____

Do you have any heart problems? YES NO Do you have stomach ulcers? YES NO

PLEASE CIRCLE THE FOLLOWING:

NEW PATIENT / FOLLOW-UP NEW PROBLEM / WORKER'S COMP

WORKER'S COMP DATE OF INURY: ____/____/____

What kind of work do you do? _____

When did your symptoms begin? _____

Where is the pain? Neck Shoulder Elbow Forearm Wrist Hand Finger

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Do you have pain with everyday use? YES NO

Does your shoulder pop? YES NO

Do you have night time pain? YES NO

Does it hurt to lie on the shoulder at night? YES NO

Do you have weakness in your hand, shoulder, or both? (PLEASE CIRCLE WHICH ONE)

Does it hurt to raise your arm over your head? YES NO

Does pain increase with use? YES NO

Does it hurt to raise your arm behind your back? YES NO

Do you have any other joint pain? If yes, which ones? _____

Are you having any numbness or tingling radiating into your fingers? YES NO

Do you have any numbness or tingling that radiates into your fingers while sleeping? YES NO

What Treatment Have You Tried For This Problem:

MRI _____

INJECTIONS _____

MEDICATIONS _____

SURGERY _____

THERAPY _____