

TENNESSEE ORTHOPAEDIC ALLIANCE

| | | | | | |
|---|--|---|--|---|--|
| For Office Use Only: | | Date: _____ | Account # _____ | <input type="checkbox"/> New | <input type="checkbox"/> Update |
| Patient's Legal Name: | | | | Previous Last: | |
| Last: | | First: | Middle: | | |
| Social Security: | | Birthdate: | Sex: | | |
| Billing Address: (Please do not use a PO Box number) <input type="checkbox"/> Current <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mailing | | | | | |
| Street: | | Apt.# | City: | State: | Zip: |
| Secondary Address: (Please do not use a PO Box number) <input type="checkbox"/> Current <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mailing | | | | | |
| Street: | | Apt.# | City: | State: | Zip: |
| Race* <input type="checkbox"/> White* <input type="checkbox"/> Asian* <input type="checkbox"/> Black/African Am.* <input type="checkbox"/> Native Am.* <input type="checkbox"/> Pacific* <input type="checkbox"/> Other* <input type="checkbox"/> Decline* | | | | | |
| Language* <input type="checkbox"/> English* <input type="checkbox"/> Spanish* <input type="checkbox"/> Other* <input type="checkbox"/> Decline* | | | | | |
| Ethnicity* <input type="checkbox"/> Not Latino* <input type="checkbox"/> Latino* <input type="checkbox"/> Unknown* <input type="checkbox"/> Decline* *Required by Federal Government | | | | | |
| Marital Status: | | Student Status: | | Family or Primary Care Physician: | |
| Home Phone: (Include Area Code) | | Day Phone: (Include Area Code) | | Alternate Phone: (Include Area Code) | |
| () | | | | | |
| Cell Phone: (Include Area Code) | | Email: | | | |
| () | | | | | |
| Patient Employer (or school): | | | Patient Occupation: | | |
| Spouse's Name: | | Spouse's Social Security: | Spouse's Date of Birth: | Spouse's Daytime Phone: | |
| | | | | | |
| Emergency Contact: (Not living in Same Household) | | | Contact's Phone: (Include Area Code): | | |
| | | | () | | |
| Emergency Contact's Address: | | | | | |
| Street: | | Apt.# | City: | State: | Zip: |
| Contact's Relationship to Patient: | | | | | |
| IF PATIENT IS RESPONSIBLE FOR ALL AMOUNTS DUE, PLEASE SKIP TO INSURANCE SECTION | | | | | |
| Name of Responsible Party for Payment | | | | Social Security #: | |
| Last: | | First: | Middle Initial: | | |
| Responsible Party's Relationship to Patient: | | | Sex: | Date of Birth: | Marital Status: |
| <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Legal Guardian | | | <input type="checkbox"/> Female | | <input type="checkbox"/> Married <input type="checkbox"/> Single |
| <input type="checkbox"/> Other (specify): _____ | | | <input type="checkbox"/> Male | | <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed |
| Address of Responsible Party: | | | | | |
| Street: | | Apt.# | City: | State: | Zip: |
| Responsible Party Home Phone (Include Area Code) | | Responsible Party Work Phone (Include Area Code) | | | |
| () | | () | | | |
| <input type="checkbox"/> PRIMARY INSURANCE | | Insurance Company Name: | | Insured's Employer: | |
| High-deductible plan? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Subscriber ID: | | | Group ID: | | |
| Policy Holder's Information: Patient's Relation to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other | | | | | |
| Name: | | Birthdate: | Social Security #: | Sex: | |
| | | | | | |
| <input type="checkbox"/> SECONDARY INSURANCE | | Insurance Company Name: | | Insured's Employer: | |
| High-deductible plan? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Subscriber ID: | | | Group ID: | | |
| Policy Holder's Information: Patient's Relation to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other | | | | | |
| Name: | | Birthdate: | Social Security #: | Sex: | |
| | | | | | |

I acknowledge that all of the above information is correct. I hereby authorize TOA physicians and staff to perform upon me or the above named patient any examination(s), x-rays, and/or tests required for treatment of my orthopaedic illness or injury.

DATE: _____ **PATIENT/PARENT/GUARDIAN:** _____

Your personal Information **PI**

Age _____ I prefer to be called _____ Who referred you to our office? _____
 Employer _____ Occupation _____ Education level _____
 School, if a student _____ Grade _____ Current sport _____

Additional information about you

****Required by Federal Government***

SH*

Height * _____ Weight * _____ Handed Right Left
 Tobacco* Current every day smoker* Smoker, no details* Former smoker*
 Current some day smoker* Never smoker* Decline*
 If current or past smoker: Packs per day _____ Years of smoking: _____
 Alcohol use None Rarely Socially Daily
 Recreational drug use None Rarely Socially Daily

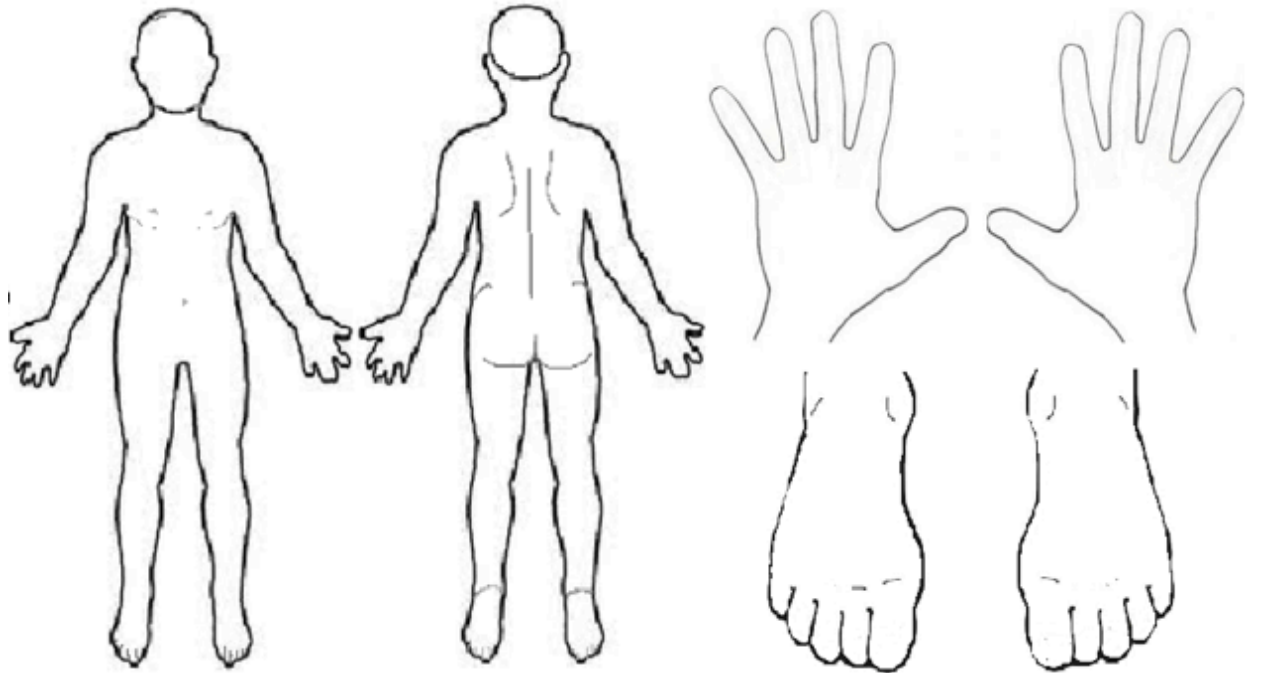
Your ORTHOPAEDIC problem today

HPI

Part(s) of your body _____ Right Left
 Describe your problem _____
 Injury or onset date _____ Date first treated _____ This was an injury
 Motor vehicle accident Sports _____ Other _____
 Work-related A lawyer is involved A lawyer will be involved
 Tests done already Xrays MRI CAT scan Other _____
 Treatment Non-prescription meds Prescription meds Ice Injected Physical therapy
 Surgery _____ Other _____

Using the symbols below, mark on the body, hands, or feet where you feel the following:

Numbness =====
 Pins/Needles oooooo
 Burning xxxxxx
 Stabbing /////
 Aching ++++++



| | | | | | | | | | | | | | |
|-----------------------|------|---|---|---|---|---|---|---|---|---|---|----|--------|
| Severity of pain | None | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Severe |
| Functional limitation | None | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Severe |

Special Alerts

I have none of the following conditions

ALERTS

- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> Blood thinners | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Peptic ulcers | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Jehovah's witness | <input type="checkbox"/> Previous MRSA | <input type="checkbox"/> Past phlebitis or embolism | |

Your other medical conditions

No other medical conditions

PMH

- | | | | | |
|-------------------------------------|---|--|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Hiatal hernia/reflux | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Gout | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Alzheimers | <input type="checkbox"/> Cardiac artery disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Spinal stenosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Degenerative joints | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Inflam. bowel/Crohn's | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Heart valve dx |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Juvenile rheum. arth. | <input type="checkbox"/> Peripheral vasc. dx | |
| <input type="checkbox"/> Atrial fib | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Rheumatoid arth. | |
| <input type="checkbox"/> Cancer | | | | |
| <input type="checkbox"/> Stroke | | | | |

Other _____

Your prior surgeries

No prior surgeries

PMH

- | <input type="checkbox"/> | Date | <input type="checkbox"/> | Date | <input type="checkbox"/> | Date | <input type="checkbox"/> | Date |
|--|------|--|------|---|------|--|------|
| <input type="checkbox"/> ACL surgery | | <input type="checkbox"/> Back surgery | | <input type="checkbox"/> Hernia repair | | <input type="checkbox"/> Rotator cuff repair | |
| <input type="checkbox"/> Angioplasty | | <input type="checkbox"/> CABG/Heart bypass | | <input type="checkbox"/> Hip arthroplasty | | <input type="checkbox"/> Small bowel resection | |
| <input type="checkbox"/> Angioplasty and stent | | <input type="checkbox"/> Heart valve replaced | | <input type="checkbox"/> Hip replacement | | <input type="checkbox"/> Thyroidectomy | |
| <input type="checkbox"/> Arthroscopy ankle | | <input type="checkbox"/> Carpal tunnel release | | <input type="checkbox"/> Knee replacement | | <input type="checkbox"/> Tonsillectomy | |
| <input type="checkbox"/> Arthroscopy elbow | | <input type="checkbox"/> Gallbladder removal | | <input type="checkbox"/> Laminectomy | | <input type="checkbox"/> Hysterectomy | |
| <input type="checkbox"/> Arthroscopy hip | | <input type="checkbox"/> Colon removal | | <input type="checkbox"/> Meniscus surgery | | <input type="checkbox"/> Mastectomy | |
| <input type="checkbox"/> Arthroscopy knee | | <input type="checkbox"/> Colostomy | | <input type="checkbox"/> Muscle biopsy | | <input type="checkbox"/> Lumbar fusion | |
| <input type="checkbox"/> Arthroscopy wrist | | <input type="checkbox"/> Disc surgery | | <input type="checkbox"/> Fracture surgery | | <input type="checkbox"/> Cervical fusion | |
| <input type="checkbox"/> Arthroscopy shoulder | | <input type="checkbox"/> Gastric bypass | | | | | |

Other _____

Other symptoms or complaints that you have

No other symptoms or complaints

ROS

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Chills | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Cold intolerant | <input type="checkbox"/> Contact allergy |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Leg swelling | <input type="checkbox"/> Heat intolerant | <input type="checkbox"/> Itchy skin |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Syncope or fainting | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Skin infections |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Skin lesion |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Constipation | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Black tarry stools | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Bruising |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Nausea | <input type="checkbox"/> Insomnia | |
| <input type="checkbox"/> Vision loss | <input type="checkbox"/> Vomiting | | |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Painful urination | | |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Frequent urination | | |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Bloody urine | | |
| <input type="checkbox"/> Recent infections | <input type="checkbox"/> Urinary incontinence | | |
| <input type="checkbox"/> Known TB exposure | | | |

Other _____

Patient _____

Date _____

Your FAMILY'S medical history

No significant family medical history

FH

| | Mother | Father | Brother | Sister | | Mother | Father | Brother | Sister |
|---------------|--------------------------|--------------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Deceased | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Liver disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Parkinson's | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Peripheral vascular dx | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Colitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |

Your MEDICATIONS*

No Medications

MEDS*

Preferred Pharmacy: _____

Phone: _____

| | If known | If known |
|------------------|----------|---------------|
| Medication Name* | Dosage | Times per Day |
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| | If known | If known |
|------------------|----------|---------------|
| Medication Name* | Dosage | Times per Day |
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Your ALLERGIES*

No Allergies

ALLERGIES*

| Medication Name* | Type of Reaction |
|------------------|------------------|
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| Medication Name* | Type of Reaction |
|------------------|------------------|
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Office Use Only - This Page

Patient _____

Date _____

Nurse's Notes

Height* _____ Weight* _____

BP* _____ / _____

NN*

Provider Notes:

Assessments (ICD-9 coding):

Medication prescriptions: ePrescribe if possible

Lab Tests:

Casts or Splints:

DME items:

Injections or Office Medications:

Follow-up (RTC) or Referral:

Work/School/Sports Restrictions and Instructions:

Office Procedures or Fracture Care:

Schedule Surgery:

Schedule MRI or other Imaging: TOA if possible

Schedule EMG/NCS or Vascular Studies:

Schedule PT/OT: TOA if possible



Patient Name _____

Account Number _____

Patient Financial Responsibility

I acknowledge full financial responsibility for services rendered by Tennessee Orthopaedic Alliance. I understand that I am responsible for prompt payment of any amounts due including, but not limited to: co-pays, deductibles, and coinsurance amounts. I understand that payment of co-pays, deductibles and coinsurance amounts are expected at time of service, as well as any prior balances I may owe. I also consent that payment of authorized Medicare and any other insurance benefits may be made on my behalf directly to TOA for any medical and/or therapy, imaging, and/or surgical services furnished. I agree to be responsible for all reasonable attorney fees and collection costs in the event of default of payment of my charges, as outlined in office and financial policy guidelines.

Signed _____ Date _____

Printed Name _____

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I authorize Tennessee Orthopaedic Alliance physicians and staff to render medical treatment and evaluation needed. I further authorize order of x-rays, injections, casting or other diagnostic tests and treatment that may be necessary to diagnose and treat my illness or injuries. I hereby give my consent to TOA to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all protected health information contained in the patient record of

_____. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice. I also understand that I will not be able to revoke this consent in cases where my provider has referred to it for purposes of disclosing my health information. Written revocation of consent must be sent to the physician's office, Attn: Administration.

Signed _____ Date _____

Printed Name _____

Acknowledgment – Notice of Privacy Practices

I hereby acknowledge receipt of TOA's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential protected health information. I have reviewed TOA's Notice of Privacy Practices. I understand that TOA reserves the right to change its privacy practices that are described in that Notice. I also understand that any Revised Notice will be posted on TOA's website, available at each office, or mailed upon request.

Signed _____ Date _____

Printed Name _____

If you are not the patient, please specify your relationship to the patient _____