CURTIS ORTHOPEDICS
Get back to where you started

Today's Date: ___________________________________ Email: __________________________________

Name: ____
(Last) (First) (MI) (Nickname)

Marital Status: ___________ Sex: M F Date of Birth: ___/___/___ Age: ______ SS#: _______________

Address: ____
(Street Number or P.O. Box) (City) (State) (Zipcode)

Home Phone: ______________________ Cell: ______________________ Work: ______________________

Emergency Contact: ____ Phone Number: ________________

Patient's Employer: ________________________ Occupation/Job Title:____________________________

Name of Spouse: _______________________________ Spouse Employer: __________________________

Primary Insurance: _____________________________ Secondary Insurance: ________________________

Policy Holder's Name: ___________________________Policy Holder's Name: _______________________

Relationship to Patient:__________________________Relationship to Patient: _____________________

Date of Birth: ___/___/___ SS#: __________________ Date of Birth: ___/___/___ SS#: ______________

Contract #: _________________ Group #: _________ Contract #: _____________ Group #: __________

Policy Holder's Employer: _______________________ Policy Holder's Employer ____________________

Primary Care Physician: ____

Please list any other doctor, coach, or trainer you want to receive a report:

____

Is this a WORKER'S COMPENSATION CASE? Yes ____ No ____

If yes, please provide the following:

Date of Injury: ___/___/___ Employer: _______________________________________

Work Comp Carrier: _______________________ Address: _______________________________________

Medical History

Current Height: ____________________ **Current Weight:** ____________________

Please list ANY drug allergies: ____

Do you wear dentures? Yes ______________ No ______________

Are you currently under a pain management contract with another physician? Yes __________ No_________

What are you here for today? ____

Have you seen another Orthopedic Physician for this problem? Yes __________ No_________

If yes, please list the Physician(s) you have seen: ____

Medications: Please list ***ALL*** medications and ***REASON***. (If you have more than 5 medications, please provide a list)

Medication: *Dose:* *Frequency:* *Reason for Medication:*

1.____

2. ____

3. ____

4. ____

5. ____

Are you currently taking any blood thinners: Yes _________ No _________
Do you have any history of blood clots (DVT): Yes _________ No _________

Past Surgeries: Please list ***ALL*** surgeries you have had in the past.

1.____ 2. ____

3.____ 4. ____

Medical History/Problems: *(IE hypertension, diabetes, high cholesterol)*

1.____ 2. ____

3.____ 4. ____

Social History:

Alcohol: Occasional ___ Daily ___ Heavy ___ No Consumption ___

Tobacco: Yes ___ No ____ Years Used ___ Packs Per Day ___

Drugs: Yes ___ No ____

General History: Please check all that apply

GENERAL:

__Weight Change

__Fever or Chills

__Night Sweats

__HIV/AIDS

__Bleeding

__Lumps or Masses

__Dizziness or Fainting

__Itching or Rash

__Diabetes

__Thyroid Problems

__Cancer

EARS-EYES-NOSE-THROAT

__Hoarseness

__Vision Change

__Hearing Change

__Tinnitus

__Dentures

__Bleeding gums

CARDIOVASCULAR:

__Heart Condition

__Hypertension

__Mitral Valve Prolapse

__Thrombophlebitis

RESPIRATORY:

__Cough/Sputum

__Rheumatic Fever

__Tuberculosis

__Pleurisy

__Pneumonia

__Asthma

__COPD

URINARY/REPRODUCTIVE

__Urinary Infections

__Incontinence

__Venereal Disease

__Menopause

__Urinary Frequency

MUSCULOSKELETAL:

__Back Pain

__Joint Pain

__Joint Swelling

__Breast Lumps

NEUROLOGICAL:

__Seizures

__Paralysis

__Numbess

__Weakness

GASTROINTESTINAL:

__Difficulty Swallowing

__Nausea & Vomitting

__Jaundice

__Hepatitis

Family Medical History: *Please list all medical illness affecting your immediate family (IE parents and siblings)*

Condition: *Family Member:* *Condition:* *Family Member:*

1.__________________________________ 2. __________________________________

3.__________________________________ 4. __________________________________

FOR OFFICE USE ONLY: *Additional Nurse Notes:*

____

____

REVIEWED BY NURSE: _________________________________ **DATE:** _________________

REVIEWED BY PHYSICIAN: ______________________________ **DATE:** _________________

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Telephone 205.481.8570 Fax 205.481.7580

Authorization for Medical Treatment: The undersigned will be informed of the treatment procedures considered necessary for the patient and that the treatment/procedures will be directed by a physician and performed by employees of Curtis Orthopedics. The undersigned understands that no guarantee for assurance has been made as to the results that may be obtained from treatment. Authorization is hereby granted for treatment.

Information Privacy: Curtis Orthopedics will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed Notice of Privacy Practices to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility, on our website, and have copies available for distribution. The undersigned acknowledges receipt of this information.

Release of Information: Curtis Orthopedics is hereby authorized to disclose all or part of my information regarding medical condition, treatment, and prognosis to insurance carriers, other treating physicians, trainers, rehabilitation nurses, orthopedic technicians, and/or coaches. I also authorize Curtis Orthopedics to utilize medical information obtained during the course of my treatment in medical research and education programs, provided my name and likeness are not revealed and my privacy is completely protected.

Assignment of Insurance Benefits: In the event of the undersigned is entitled to benefits of any kind whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to Curtis Orthopedics for application on the patient's bill. The undersigned and/or patient agrees to be responsible for charges not covered by the assignment, including deductibles and co-payments prescribed by law.

Financial Agreement: The undersigned agrees that in consideration for the services to be rendered to the patient, he/she individually agrees to be totally responsible for all charges for services, including any non-covered charges. The undersigned agrees to assign payment for the unpaid charges from services provided by a specialist and by physicians for whom Curtis Orthopedics is authorized to bill. Should the account be referred to any attorney for collection, the undersigned agrees to pay all costs of collections, including reasonable attorney fees or one third of the balance. All delinquent balances shall bear interested at the legal rate.

Medical Authorization: I authorized any holder of medical or other information about me to release to Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to party of who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible in part for my treatment. (Section 11288 of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

Miscellaneous Provisions: I understand that under no circumstances will Curtis Orthopedics be liable for property of patients.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, IS THE PATIENT OR ONE AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE, AND ACCETS THE TERMS THEROF.

____
Undersigned (Patient's Signature)

____
Signature- If signed by Undersigned's Authorized Agent

____
Witness

____
Relationship to Undersigned

____
Date