OrthoGo

Today's Date: _____/_____/_____

PATIENT INFO:

Patient Name:_____ Date of Birth:_____/_____/_____

Social Security #:_____ Sex: M F Marital Status: S M D W

Mailing Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email:_____

Employer:_____ Employer phone #:_____

Emergency Contact:_____ Phone #:_____ Relationship:_____

Referring Provider:_____ Primary Care Provider:_____

PARENT OR GUARDIAN INFO: (Please list parent or guardian responsible for billing FIRST)

Legal Guardian Name:_____

Relationship: _____ Responsible Party? Y N

Social Security #:_____ Date of Birth:_____/_____/_____

Address if different from patient:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone :_____

Employer:_____ Employer Phone #_____

Legal Guardian Name:_____

Relationship:_____ Responsible Party? Y N

Social Security #:_____ Date of Birth:_____/_____/_____

Address if different from patient:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Employer:_____ Employer Phone #_____

OrthoGo

Today's Date: ____ /____ /_____

INSURANCE INFO:

Do you have medical insurance: Yes No

Is this a workers comp claim: Yes No If yes, then what is date of injury:_____

Employer at time of injury:_____ Claim #:_____

Primary Insurance:_____ _____

Member ID:_____ Group #:_____

Is patient the policy holder: Y N Policy Holders Name:_____

Policy Holder's date of birth:_____/_____/_____ Policy Holder's Social Sec #:_____

Relationship to Policy Holder:_____

Secondary Insurance:_____

Member ID:_____ Group #:_____

Is patient the policy holder: Y N Policy Holders Name:_____

Policy Holder's date of birth:_____/_____/_____ Policy Holder's Social Sec #:_____

Relationship to Policy Holder:_____

OrthoGo

Today's Date: _____ /_____ /_____

PATIENT INFORMATION

Name _____
Referring Physician_____
Height_____Weight _____
What are you being seen for today?
Body part_____ Left or Right
_____
_____
Work-related? ____Yes ____No
Other injury? ____Yes ____No
(If applicable) Injury Date_____
Claim #_____

SYMPTOMS

Describe symptoms_____
_____
_____
When (a) and how (b) did the symptoms begin?
(a)_____
(b)_____

ALLERGIES

List any drugs you are allergic to:
_____
_____
Latex allergy?____Yes ____No

MEDICATIONS

List the name and dosage of any medications that you are currently taking:
_____
_____
_____
_____
_____
_____
_____
Have you ever taken a blood thinner for any reason?
___Yes ___No If yes, what for?_____
Name of blood thinner taken:_____

MEDICAL HISTORY

Check all health problems that YOU have had:

____Heart Disease ____Kidney Issues
____Lung Disorder ____High Blood Pressure
____Stroke ____Neurological Disorder
____Asthma ____Sleep apnea
____HIV ____Depression
____Cancer (If yes, type) _____
____Diabetes (If yes, type) _____
____Hepatitis (If yes, type)_____
____Other:_____

SURGICAL HISTORY

Check all surgeries YOU have had:

____Joint Surgery ____Spine Surgery
____Heart Surgery ____Hysterectomy
____C-Section ____Tonsillectomy
____Appendectomy ____Gallbladder
____Other:_____

FAMILY HISTORY

List each relative's health problem
(siblings, parents, or grandparents):
Please list which relative had each problem:

Arthritis_____ Osteoporosis_____
Cancer_____ Diabetes_____
Heart Disease____ Scoliosis_____
Stroke_____ Lung Disease_____
Bleeding Disorder_____
____Other_____

SOCIAL HISTORY

Do you smoke? ____Yes ____No
Packs per day: _____

Do you drink alcohol? ____Yes ____No
Drinks per week:_____

Occupation_____

How did you hear about us? _____
_____

Pharmacy:_____

PATIENT CONSENT

I will provide OrthoGo with the phone numbers I authorize to contact me. I authorize the use of any messaging person or system, voicemail, and/or an answering machine to convey information regarding my care. I authorize the use of faxing or email to send my information to myself or to other parties that have a right to receive my information. I understand that every effort is made to protect my privacy; however, no absolute privacy guarantee is given especially when fax or email is used.

FINANCIAL RESPONSIBILITY

I hereby authorize OrthoGo to furnish all information regarding my medical history, diagnosis, treatment, of myself or my child (if applicable) to an insurance company regarding my claims for benefits. If however, said insurance fails to meet this obligation, in whole or in part, or if I am uninsured I agree to be responsible for the fee and cost involved in the treatment of the patient. I authorize payment of medical benefits to OrthoGo and further understand that should my account need to be referred to an attorney for collection that I am responsible for all fees and costs incurred with this. I hereby authorize OrthoGo to act on my behalf and access hospital or other outside medical records when and if needed.

CONSENT FOR TREATMENT

I consent to the care and treatment by OrthoGo. The treatment may include but is not restricted to medications, anesthesia, surgical and invasive procedures, lab, x-ray, or other studies that may be helpful in the performance of the patient's care.

Authorization for release of medical records: I authorize the release of any and all medical records or information, including psychiatric, drug, alcohol, HIV, substance abuse records etc., to the referring physicians or agencies involved in the patient's care, insurance carriers or those involved in the payment of the patient's account, or others involved in the performance of quality assurance.

Exposure to Diseases: I understand that if my physician(s) or any person employed by or under the direction and control of my physician(s) is directly exposed to my body fluids in any manner which may, according to the current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or Hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV, Hepatitis B, and/ or Hepatitis C viruses. I further understand that by law I will have deemed to have consented to the release of these test results that are exposed to by body fluids.

CONSENT TO OBTAIN MEDICATION HISTORY

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.
Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from
my pharmacy, my health plans, and my other healthcare providers.

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.
A photocopy or electronic document of the authorization shall be considered as effective and valid as the original.

_____ _____

Patient or Guardian Signature Date