

DATE: _____

PATIENT INFORMATION (4 SHEETS)

CHART #: _____

Patient Information		
PATIENT'S NAME: (Last)	First	M.Init.
LOCAL ADDRESS... Street		Unit/Apt. #
City	State	Zip Code
SEX...	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
EMPLOYER		
EMPLOYER's Address... Street		Suite/Unit
City	State	Zip Code
PRIMARY LANGUAGE		
HOME PHONE Area Code ()	WORK PHONE Area Code ()	
DATE OF BIRTH	AGE	
DRIVERS LIC. #	ST	
SOCIAL SECURITY #		
<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW(ER) <input type="checkbox"/> CHILD/STUDENT		
PERMANENT ADDRESS: (if different from local above)		Unit/Apt.#
City	State	Zip Code
PHONE NUMBER for Permanent Location Area Code ()	EMERGENCY CONTACT... Area Code ()	
REFERRED BY?	FAMILY PHYSICIAN:	

Primary Insurance Coverage	
NAME & ADDRESS OF INSURANCE COMPANY:	
CERT. #	GROUP #
INSURANCE THROUGH EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
INSURED'S NAME & Relationship to patient?	Date of Birth

Secondary Insurance Coverage	
NAME & ADDRESS OF INSURANCE COMPANY:	
CERT. #	GROUP #
INSURANCE THROUGH EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
INSURED'S NAME & Relationship to patient?	Date of Birth

Spouse's Information		
NAME: (Last)	First	M. Init.
SOCIAL SECURITY #	DATE OF BIRTH:	
EMPLOYER:		
EMPLOYER's Full Address...		
WORK PHONE Area Code ()	OCCUPATION:	

Spouse's Insurance Coverage	
NAME & ADDRESS OF INSURANCE COMPANY:	
CERT. #	GROUP #
INSURANCE THROUGH EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
INSURED'S NAME & Relationship to patient?	Date of Birth

Complete If Patient Is Child or Student		
FATHER'S Full Name (Last)	First	M. Init.
SOCIAL SECURITY #	DATE OF BIRTH:	
ADDRESS (If different from child/student)...		
EMPLOYER:		
EMPLOYER's Full Address...		
HOME PHONE Area Code ()	WORK PHONE Area Code ()	
MOTHER'S Full Name: (Last)	First	M. Init.
SOCIAL SECURITY #	DATE OF BIRTH:	
ADDRESS (If different from child/student)...		
HOME PHONE Area Code ()	WORK PHONE Area Code ()	

Authorization For Treatment:
I hereby give my permission for Orthopaedic Surgery Associates, Inc. to evaluate and treat as deemed medically necessary.
SIGNED: _____ (Parent or Guardian) If Patient is a minor.

Name: _____ Date: _____

Have you/ or are you being treated for the following: Include dates

1. ENDOCRINE:

- Diabetes
- Thyroid disorders
- Fever
- Weakness
- Chills
- Night sweats
- Recent change in weight or appetite

2. SKIN AND HEMATOLOGIC:

- Skin color
- Texture
- Frequent infections
- Varicosities
- Coagulation disorders
- Anemia

3. CNS:

- Unusual headaches
- Migraines
- Loss of consciousness
- Epilepsy
- Head trauma
- Seizure disorders
- Stroke
- Loss of memory
- Vertigo
- Syncope
- Paralysis
- Numbness/tingling in extremities

4. EYES:

- Glaucoma
- Cataracts
- Change in vision
- Use of glasses for reading

5. EARS:

- Buzzing or ringing in ears (tinnitus)
- Change in hearing
- Use of hearing aid
- Earache
- Discharge from ears

6. NOSE AND MOUTH:

- Airway obstruction
- Difficulty Speaking
- Sinus problems
- Unusual bleeding
- Dentures

7. BREASTS:

- Masses
- Cystic condition
- Past biopsy or surgery

8. RESPIRATORY:

- Cough
- Coughing up blood
- Asthma
- Bronchitis
- Shortness of breath at night
- Emphysema
- Pneumonia
- Tuberculosis
- Congestive failure

9. CARDIOVASCULAR:

- Anginal chest pain
- Heart attack
- Murmurs
- Hypertension
- Stroke
- Palpitations
- Peripheral edema
- Claudication
- Poor circulation
- Congestive heart failure
- Phlebitis
- Cramping of legs when walking

10. GASTROINTESTINAL:

- Constipation
- Nausea
- Vomiting
- Diarrhea
- Enteritis
- Vomiting blood
- Melena
- Bright red blood per rectum
- Jaundice
- Abdominal hernias
- Hepatitis
- Diverticulitis
- Gallbladder disease
- Yellow jaundice
- Peptic or duodenal ulcer disease
- Abdominal pain

11. UROLOGY:

- Pain on urination
- Frequency
- Urgency
- Decreased stream
- Blood in urine
- Incontinence
- Kidney stones
- Bladder infections
- Syphilis
- Gonorrhea
- Difficulty with urination
- Burning during urination

12. MUSCULOSKELETAL:

- Joint pain
- Swelling
- Stiffness
- Muscle pain
- Arthritis
- Gout
- Deformities
- Cramps or weakness
- Prior fractures
- Decreased range or motion

PATIENT'S NAME: _____

CHART #: _____

Childhood Illnesses... NONE

List unusual illnesses such as rheumatic fever, polio, heart murmur, etc.

Vitamin Use... NONE

Daily Multivitamin
 Vitamin C (amount _____/day)
 Vitamin D (amount _____/day; or _____/week)
 Other (s), include amount/day:

Iron (amount _____/day)
 Calcium (amount _____/day)

Alcohol Usage... NONE

Infrequent Occasional Moderate Excess

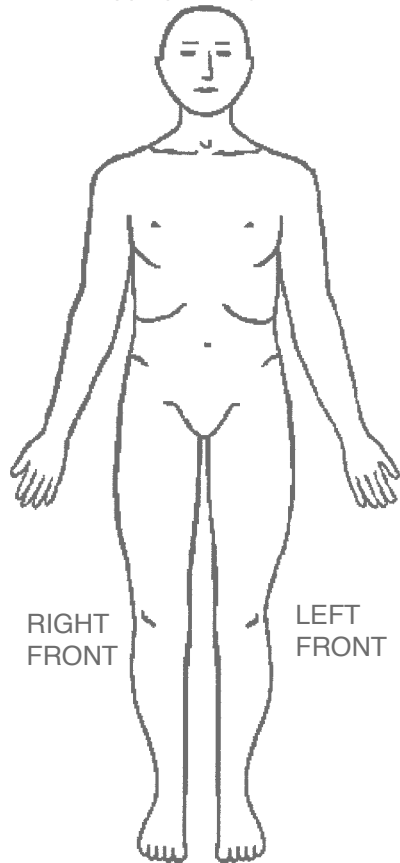
Smoking... NO YES

If yes, number of Packs/day _____ and, number of Years Smoking _____?
 Not now... Quit _____ years ago. Smoked _____ packs per day for _____ years.
 Never smoked.

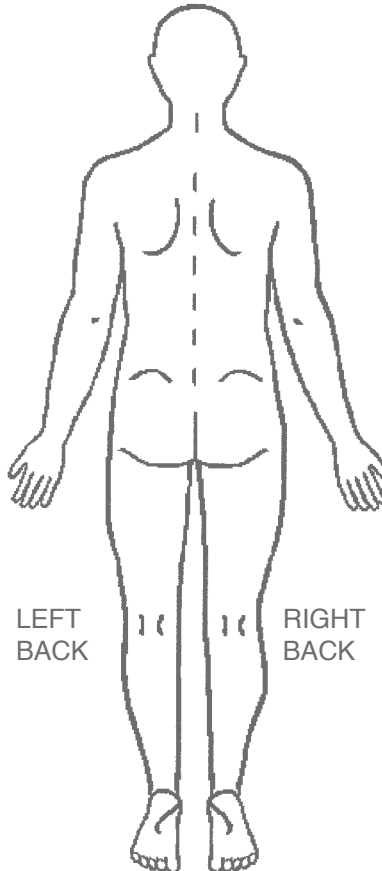
Other Information Pertinent To Your Care... NONE

RANSFORD PAIN DRAWING

Mark the areas on this body drawing where you feel the described sensations. Use the appropriate symbols. • Mark areas of radiation. • Include all affected areas.



PAIN CHART



NUMBNESS

PINS & NEEDLES
000000
000000
000000

BURNING

XXXXXXX
XXXXXXX
XXXXXXX

ACHING

.....
.....
.....

STABBING

/////////
/////////
/////////

ON A SCALE OF 1-10, INDICATE YOUR CURRENT LEVEL OF PAIN:

- 0 - Normal
- 1
- 2
- 3 - Low Pain
- 4
- 5 - Moderate Pain
- 6
- 7
- 8 - Intense Pain
- 9
- 10 - Emergency

READ & SIGN THE AUTHORIZATION ON PAGE ONE, AND PRESENT YOUR INSURANCE CARDS TO THE RECEPTION WINDOW UPON COMPLETION.

ORTHOPAEDIC SURGERY ASSOCIATES

COMPREHENSIVE MUSCULOSKELETAL CENTERS

PATIENT'S FINANCIAL AGREEMENT

Patient's Name: _____ Date: _____

IN CONSIDERATION of the provision of services to the Patient named above, the Patient and the Responsible Party understand and agree that:

1. Payment for services rendered is due in full forty-five (45) days from the date services were rendered, or as otherwise might be stipulated through a contract between OSA and Patient's health plan or as stipulated by any state prompt payment laws. Any balance unpaid after sixty (60) days from the date services were rendered will be considered "delinquent". OSA will assist the Patient in the processing of insurance claims as a courtesy only. OSA accepts no responsibility for any processing procedures, acts, omissions and/or neglect. PATIENT, RESPONSIBLE PARTY AND/OR INSURANCE CARRIER ARE SOLELY RESPONSIBLE TO PAY FOR ALL SERVICES PROVIDED.

2. FOR PATIENTS WITH INSURANCE: In the event that services rendered are not covered or are deemed as not medically necessary, Patient and/or Responsible Party shall be responsible for payment in full for those services. Patient and/or Responsible Party shall also be responsible for any cost sharing, such as co-payments, coinsurance and/or deductibles prior to services being rendered..

3. In the event that any unpaid balance remains delinquent and has been placed for collection, the Patient and/or Responsible Party must pay all costs of collection, including reasonable attorney's fees, if the delinquent balance is referred to an attorney for collection.

4. In the event the Patient submits payment by check and that check is returned for INSUFFICIENT FUNDS by the Bank, OSA will add a bank charge to the balance owed by the Patient or Responsible Party.

5. No statement by an employee or agent of OSA will contradict, void or nullify this Agreement, nor shall the Patient rely on any statements or opinions made by OSA that Patient's insurance carrier will pay the bill.

6. Patient also agrees to assign to OSA the rights under their policy of insurance, including medical benefits, the right to receive information concerning benefits available, and the right to file a lawsuit to recover unpaid medical benefits for OSA's charges.

7. All patients who fail to arrive for their scheduled appointments or who cancel with less than 24 hours advance notice will be charged a missed appointment fee of \$25.00.

X-RAYS: Original X-rays are a part of the patient's permanent medical chart and remain in our office. If you would like a copy of your X-rays, there is a nominal charge to cover the cost of duplication.

LIFETIME AUTHORIZATION - MEDICARE AND MEDICAID PATIENT CERTIFICATION - PATIENT CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians services. I understand that I am responsible for my health insurance deductibles and co-insurance.

Authorization is hereby given to OSA to submit my claim directly to my insurance on my behalf. I understand that by signing this form, my signature is not needed each time a claim is submitted on my behalf. I further authorize my insurance carrier to forward payment directly to OSA.

I HEREBY AUTHORIZE OSA TO RELEASE ALL MEDICAL AND BILLING INFORMATION NECESSARY TO SECURE PAYMENT FROM MY DESIGNATED INSURANCE CARRIER ON MY BEHALF. I have read and fully understand all of the above conditions. Once I sign this Agreement, I am responsible for all payments, charges, and if necessary, costs of collection as stated above. I acknowledge receipt of a copy of this Agreement.

Patient: _____

Dated: _____

Responsible Party (if other than Patient):

Witness: _____

Relationship to Patient