TO RECEIVE MEDICAL TREATMENT ALL QUESTIONS MUST BE ANSWERED

Patient Name: ____
First Middle Last

Address: ________________________________ **City:** ______________ **State:** _______ **Zip:** ____________

Home Phone: (_____)______________________ **Cell Phone:** (_____)________________________________

Work Phone: (____)_______________________ **Emergency Phone:** (____)________________________

Social Security #: ____________________ **Age:** ____ **Date of Birth:** _____________ **Marital Status:** _____

Student-Full/Part Time (circle one) Name of School: ____

Employer: ____ **Occupation:** ____________________________

Address: ____ **Phone Number:** (____)__________________

Family Physician: ____
Give full name and address

Referred by: ____
Give full name and address of doctor, coach, or trainer

We must have all necessary insurance information – We will make a copy of your insurance card

Spouse/Responsible party's name (if minor): _________________________ **Social Security #:** __________

Address, if different from patient: ____

Spouse/Responsible party's employer and occupation: ______________________ **Phone:** ______________

Primary Insurance Company: ___________________________________**Policy #:** ____________________

Subscriber Name: __________________ **Subscriber date of birth:** __________ **Group #:** _______________

Secondary Insurance Company: _________________________________ **Policy #:** ___________________

Subscriber Name: __________________ **Subscriber date of birth:** __________ **Group #:** _______________

Auto Accident: ___ **Yes** ___ **No** **Auto Insurance Company:** _____________________________________

Work Injury: ___ **Yes** ___ **No** **Employer at the time of injury:** ________________________________

Date of injury/accident: _________ **How accident occurred:** _______________________________________

Body part injured (specify RT or LT): ____

How did you find our phone number? **Yellow Pages** ___ **White Pages** ____ **Referring Doctor** _____

Other (Specify): ____

PLEASE READ THE FOLLOWING INFORMATION-THE RESPONSIBLE PARTY MUST SIGN ALL STATEMENTS BELOW

CONTRACT TO PAY FOR MEDICAL SERVICES: I authorize treatment and agree to pay when services are rendered or I hereby authorize insurance payment directly to Drs. Ernest A. Eggers, Donald T. McAllister, Norman V. Lewis, Richard A. Sweet, Thomas R. Lehmann, George E. Quill, Jr., Scott D. Kuiper, Ty E. Richardson, Robert A. Goodin, J. Steve Smith, Lori L. Edmonds, ARNP, Melissa D. Taylor, PA-C, Kate S. Hamilton, PA-C, Christina L. Fields, ARNP or Louisville Orthopaedic Clinic. If charges are more than paid by insurance company, I agree too pay the difference.

It is your responsibility to be informed regarding your insurance coverage. We will make every effort to assist you in obtaining authorizations for procedures necessary in your treatment, but if you neglect to inform us of your coverage, and your insurance company refuses to pay, it then becomes your responsibility to pay for services rendered. You may have to pay for all unauthorized services or all unauthorized referrals from your primary care physicians.

AUTHORIZATION: I authorize Drs. Ernest A. Eggers, Donald T. McAllister, Norman V. Lewis, Richard A. Sweet, Thomas R. Lehmann, George E. Quill, Jr., Scott D. Kuiper, Ty E. Richardson, Robert A. Goodin, J. Steve Smith, Lori L. Edmonds, ARNP, Melissa D. Taylor, PA-C, Kate S. Hamilton, PA-C, Christina L. Fields, ARNP or Louisville Orthopaedic Clinic to release any protected health information necessary to process my health, disability, liability, or workman's compensation insurance.

PATIENT SIGNATURE: ____ **DATE:** _________________

(Please print and use black or blue in only)

Patient Name: ______________________________

Date: ____________ ID#: _______________ Date of Birth: ______________ Age: ___________

Primary care physician: ______________________________

Referring physician: ______________________________

HPI (Physician's use only)

PAST MEDICAL HISTORY: (Have you ever been treated for or diagnosed with)

_____ Diabetes I
_____ Diabetes II
If yes, are you on insulin? _____
_____ History of cancer
_____ High blood pressure
_____ Stroke or TIA's
_____ Heart attack
_____ Congestive heart failure
_____ Atrial fib/irregular heartbeat
_____ Aortic aneurysm
_____ Pneumonia
_____ COPD/emphysema
_____ Asthma

_____ Gout
_____ Arthritis
____ **Rheumatoid**
___ **Osteoarthritis**
_____ Fibromyalgia
_____History of fractures
_____ Thyroid disorders
_____ Anemia
_____ High cholesterol
_____ Sleep apnea
_____ C-PAP
_____ Glaucoma
_____ History of MRSA

_____ Urinary tract infections
_____ Renal/Kidney disease
_____ Ulcers/ GERD
_____ HIV
_____ Hepatitis
_____ Tuberculosis
_____ Psychological disorder
_____ Depression
_____ Bipolar
_____ Anxiety
_____ Peripheral vascular disease

Other: ______________________________
____

If yes to any of the above, please explain: ______________________________
____

History of any surgery (procedure, year, surgeon):

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Any hospitalizations (please specify):

______________________________ ______________________________
______________________________ ______________________________

Family medical history (illness or anesthesia):______________________________
____

Patient Signature: ______________________________ **Date**: ______________________

REVIEW OF SYSTEMS: Do you **currently** have any of the following?

GENERAL:
____ Weight loss/gain
____ Fever
____ Fatigue
____ Weakness

SKIN:
____ Rashes
____ Lumps
____ Sores
____ Color change
____ Changes in hair or nail

HEAD:
____ Headaches
____ Light headedness

EYES:
____ Glasses or contacts
____ Double vision
____ Blurred vision
____ Glaucoma

EARS:
____ Hearing loss
____ Tinnitus/ringing in ears

NOSE and THROAT:
____ Bleeding gums
____ Frequent sores
____ Sinus difficulty

NECK:
____ Swollen glands
____ Thyroid enlargement
____ Stiff neck

BREASTS:
____ Lumps
____ Pain or discomfort
____ Nipple discharge

RESPIRATORY:
____ Cough
____ Shortness of breath

CARDIAC:
____ Chest pain
____ Heart palpitations
____ Swelling of ankles

GASTROINTESTINAL:
____ Difficulty swallowing
____ Heartburn
____ Decreased appetite
____ Nausea
____ Vomiting
____ Change in bowel habits
____ Abdominal pain

URINARY:
____ Burning
____ Blood in urine
____ Urgency
____ Incontinence

MUSCULOSKELETAL:
____ Joint pain
____ Stiffness
____ Muscle cramps

NEUROLOGICAL:
____ Seizures
____ Paralysis
____ Numbness
____ Tremors
____ Dizziness
____ Loss of balance

HEMATOLOGIC:
____ Easy bruising
____ Excessive bleeding
____ Past transfusions: if yes, specify date: ________

PSYCHIATRIC:
____ Nervousness
____ Depression
____ Anxiety

Date of last chest x-ray: ___________ Normal _______ or Abnormal _______
Date of last EKG: ________________ Normal _______ or Abnormal _______

Patient signature: ____ Date: ______________

(Please print and use black or blue ink)

Patient Name: ____

Pharmacy name:___________________________________**Phone#**____________________

Current Medications (dosage and frequency): Please include all vitamins and supplements

_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________

Allergies: (medicine, latex, seafood) **Reaction:**

_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________

Anti-inflammatories taken within the last 12 months: (include aspirin, ibuprofen, Advil, Aleve, Motrin, etc., as well as prescription anti-inflammatories)

_________________________________ _________________________________
_________________________________ _________________________________

Social History:
Occupation: ____
Status: Married _____ Single _____ Other ____
Number of children: _______ If female, are you currently pregnant? _________________________
Do you live alone: ____
Do you use tobacco? _________ If yes, how often? ____________________________________
Do you drink alcohol? ________ If yes, how often? ____________________________________

Physician's use only:

HEENT:
NECK:
CHEST:
HEART:
ABDOMEN:
G.U.:
ORTHOPAEDIC:

____
____

Physician Signature: ____ Date: _____________

Patient Signature: ____ **Date:** ______________

Louisville Orthopaedic Clinic

Notice of Privacy Practices Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by visiting our web site at www.louisvilleorthopedic.com or by requesting a paper copy.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

______________________________________ _____________________
Patient's Name Printed Patient's Date of Birth

______________________________________ _____________________
Patient or Guardian's Signature Relationship to Patient
(Patient must sign if 18 or over unless you have Power of Attorney; if Power of Attorney, please attach a copy of order)

____
Today's Date

AUTHORIZATION FORM

As referred to in the "Louisville Orthopaedic Clinic's Notice of Privacy Practices", you have the right to restrict who will have access to your protected health information. At the same time, this limits our ability to communicate protected health information to anyone without your **written** consent, even to family members who may be contacting us on your behalf. Please use this form to authorize release of information to anyone of your choice.

I authorize the release of information about me, including any protected health information, by Louisville Orthopaedic Clinic, to the following:

Name	Relationship	All Info	Scheduling	Billing	Test Results	Other as Listed Below
example: Jane Doe	daughter		√	√		pick up prescriptions/samples
Voicemail or Answering Machine	Home Phone					
	Work or Alternate #					

My Protected Health Information may be released to the above people as authorized effective from date signed until such time as I revoke it in writing.

Do not release any information to anyone other than myself until notified in writing to the contrary. ☐

Patient's Name Printed

Patient's Date of Birth

Patient or Guardian Signature
(Patient must sign if 18 or over unless you have Power of Attorney; if Power of Attorney, please attach copy of order.)

Relationship to Patient if other than self

Date