PATIENT INFORMATION

PATIENT'S NAME____
LAST FIRST MIDDLE NICKNAME

DOB ________________ AGE ____________SEX_________ SS#______________________________

MAILING ADDRESS____
STREET ADDRESS . CITY STATE ZIP

MOBILE #________________ HOME #______________ E-MAIL________________________________

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ MINOR

IF PATIENT IS A MINOR, GIVE PARENT OR GUARDIAN'S NAME: ____________________________________

PARENT/GUARDIAN DOB: _________________ RELATIONSHIP TO MINOR: _______________________

PATIENT WORK INFORMATION (IF PATIENT IS A MINOR, PROVIDE PARENT INFO)

EMPLOYER ____OCCUPATION_____________________

EMPLOYER'S ADDRESS _______________________________ WORKPHONE________________________
STREET, CITY, STATE, ZIP

NAME OF SPOUSE____ DOB _____________________

SPOUSE'S EMPLOYER ________________________________ WORK #____________________________

SPOUSE'S EMPLOYER ADDRESS ____
STREET, CITY, STATE, ZIP

NAME OF INSURANCE (or responsible party for payment) _______________________________________

OTHER INFORMATION

HOW DID YOU HEAR ABOUT US?____

FAMILY DOCTOR'S NAME ____________________________ PHONE NUMBER_____________________

EMERGENCY CONTACT PERSON (PROVIDE - Name / Relationship to patient / Phone Number / Address):

____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Advanced Orthopaedic Institute to release any medical or other information necessary for the processing of insurance benefits for medical and/or surgical services rendered. I authorize Advanced Orthopaedic Institute to release any medical or other information to other medical care providers or administrative parties for purposes of coordinating and documenting my treatment.

____ __________________________

Signature of Patient, Parent, or Guardian Date

MEDICAL INFORMATION

PATIENT'S NAME____DATE__________

AREA OF BODY TO BE EXAMINED (Rt / Lt) ____

Date of injury, if applicable: (N/A) ____

How did injury occur? (N/A) ____

Where did injury occur? (N/A) ____

Describe your symptoms____

If no injury, approximate date of onset of symptoms ________________________________

First date of treatment other than this office (N/A) ___________________________________

Type of treatment: (N/A) ____

Were X-rays taken? (Y / N) ……… If yes, when and where?______________________________

Has an MRI been Done? (Y / N) …………If yes, when and where?_________________________

Are there any Attorneys or is Workers Compensation involved in this injury? (Y / N)
if Yes Specify: ____

GENERAL MEDICAL

Are you allergic to any medications? (Y / N) …………… If Yes, please list: ____________________
____
____

Height ____________ Weight ____________

Have you had or do you now have:

Diabetes.. NO _________ YES __________
Heart Disease... NO _________ YES __________
High Blood Pressure .... NO _________ YES __________
Liver Disease... NO _________ YES __________
Kidney Disease .... NO _________ YES __________
Cancer... NO _________ YES __________
Allergies.. NO _________ YES __________
Any other Medical information we need to know? Please describe. ____________________________
____

Have you been hospitalized in the last 5 years? (Y / N) If yes, for what reason?
____

Previous Surgeries, LIST:____

Current medications: ____

Are you pregnant or is there any chance you might be pregnant?..................................... (Y / N)

_______________________________ _______________________
Signature of Patient, Parent, or Guardian Date

ADVANCED ORTHOPAEDIC INSTITUTE
PATIENT FINANCIAL POLICY

Patient Name:________________________________ Date of Birth:____________

Guarantor's Name:____________________________ Relationship:____________

Thank you for choosing us for your Orthopaedic care. Like any business, we have office policies that we must adhere to so that we may operate in a manner that will benefit our relationship. We will define those policies in the following paragraphs. Please read and initial each paragraph and sign at the bottom. If you have any questions or would like a copy please let one of our team members know.

Methods of Payment accepted are: Cash, Checks, Visa, MasterCard, Discovery, American Express and Care Credit.

__________ We try very hard to adhere to a schedule. If you are more than 15 minutes late we may have to reschedule your appointment. We respect your time and will make every effort to stay as close to your appointment time as possible. We thank you for choosing our orthopaedic practice and look forward to a great relationship with you and your family.

__________ We must have at least a 3-hour notice should you be unable to come to your appointment. We will make every effort to confirm your appointment with you. However, it's ultimately your responsibility to keep your appointment once it has been made. Failure to give us a 3-hour notice will result in a $25 cancellation fee that will be billed to your account**. Appointments scheduled during the peak times of 8AM, 4:30PM & 5:00PM appointments, and all day Saturday require a 24-hour cancellation notice. We bring in extra staff to accommodate our patients during these peak times.** Cancelled and Missed appointments may result in a required credit card on file for future scheduling.

__________ **IF YOU HAVE HEALTH INSURANCE:**
We will file claims for you.

We must have complete insurance information and verification prior to your visit.

Amounts estimated to be your responsibility are due at time of service. This usually means your deductible, if applicable, and percentage of copayment defined by your insurance policy (e.g. 20%, or $15 copay)

Surgery will require a deposit at time of scheduling. The amount of the deposit will be determined by the manager based on your insurance policy.

__________ **IF YOU WILL BE PAYING YOUR BILLS YOURSELF (self pay):**
Our fees are due in full at the time of service. Discounts are considered and given.

I have read, fully understand, and agree to the financial policy above.

______________________________________ ________________
Signature of Patient, Parent, or Guarantor Date