NORTHTOWNS ORTHOPEDICS, P.C. DATE:____________________

PATIENT INFORMATION

Name:____ Birth date:_______________

(Parent name if not patient):____

Address:__________________________________ City:_________________ State:___________ Zip:_________

Phone: Home ( ) __________________ Work ( ) __________________ Cell ( ) _________________

SS#: _____-____-_______ Occupation: _______________________________ Gender: M F

Employer and Employer's address: ____

Primary Physician: _________________________________ Phone: ( ) ___________________________

Address: ____

Referring Physician: ________________________________ Phone: ( ) ____________________________

Emergency Contact: _________________________________ Phone: ( ) ____________________________

Current Pharmacy name and phone #: ____

Is the reason for your visit today related to your employment or a car accident? No Yes
If yes, the staff will provide an additional form.

Insurance information: Name of insurance plan: ____

ID# _________________________________ Group# _________________________ Plan# __________________

Subscriber name (if not self): ____

Subscriber DOB: ____/____/________ Subscriber Social Security #: _______________________________

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

I hereby authorize Dr. Kevin Lanighan and Northtowns Orthopedics, P.C. to release medical and other information relative to services rendered, to perform services necessarily incident to such treatment, and to ensure confidentiality.

I hereby authorize payment of medical benefits to the above named doctor and Northtowns Orthopedics, P.C. and I understand that I am financially responsible to the physician and Northtowns Orthopedics, P.C. for charges not covered by my insurance carrier, unless other arrangements have been made. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney fees and collection agency expenses.

I understand should my claim be rejected by an insurance company or is determined that my claim was not a result of Worker's Compensation or an automobile accident, the undersigned shall pay the usual and customary fees for services rendered.

Signature: ____

Patient Name: ____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, ____, have received a copy of Northtowns Orthopedics' Notice of Privacy Practices.

Patient Signature: ____ Date: _________________________

Leave appointment message on:

____ Answering machine ____ Office voicemail ____ With another person ____ Sent through the mail

May we leave any other medical information on:

____ Answering machine ____ Office voicemail ____ With another person ____ Sent through the mail

Person authorized to discuss the above: ___________________________________ Relationship: ___________

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Northtowns Orthopedics to disclose certain protected health information about me to

____(spouse, parent, immediate family member, other) for the following purpose:

____ Any purpose

____ Specific medical condition or service date

____Other _____________________________________

Patient Signature: ____ Date: __________________________

COVERAGE DETERMINATION

____ It is my intention to pursue this as a work related problem. I understand it is my responsibility to file a Workman's Compensation claim. If I fail to prosecute the claim, or if it is determined by the Workman's Compensation board that this is not work related, I agree to pay Northtowns Orthopedics their usual and customary fees for services rendered. I understand my regular health insurance is required at my time of visit as a back up and I am responsible for obtaining any necessary referrals, if applicable.

____ I do not feel this visit is job related. I understand my regular insurance is required and I am responsible to obtain any referrals necessary. If I file a workman's compensation claim at a later date I understand that today's services (including x-rays, etc.) may not be covered as a result of being prior to the claim filing date for workman's compensation and/or if my regular insurance denies it as being work related I am responsible for the charges.

____ I am unsure if the problem I am being seen for is work related. I will discuss it with the doctor/P.A. so I understand my options. At the end of the visit I will choose one of the above options.

I understand any misrepresentation I give of my injury/illness as being work related or not may be considered fraudulent and as such I may be responsible for any unpaid charges.

Patient Signature: ____ Date: ___________________________

NORTHTOWNS ORTHOPEDICS, P.C.

MEDICAL HISTORY

Patient Name: ______________________________ Date: ________________

Age: ______ Height: _______ Weight: _______

What is your current complaint? ____

How did your current problem begin? (ex. Injury/car accident etc.) _____________________

How long have you had symptoms? ____________________________________

Do you experience any of the following (please circle all that apply):

Numbness/Tingling   Clicking/Locking   Weakness   Pain

Pain with pinching/Grasping   Swelling   Stiffness

On a scale of 1-10 how would you rate the pain (1 being the least, 10 being the most)? ______

What makes your pain worse?	What makes your pain better?
Activity	Rest
Overhead/Reaching	Brace (type/how long used?) ___________
Nighttime	Medications ___________________
Lifting	Therapy (How long did you attend?) _______

Is there any radiation of the pain? No Yes (If so, where?) _________________________

Please circle any of the following tests you have had in regards to this particular problem:

X-rays   MRI Scan   EMG/Nerve Condition Test   Other: ____________

Review of Systems: Do you currently or have you ever had any of the following (please circle):

Eye/Vision Problems	Hearing Difficulties	Throat/Swallowing Difficulties
Gastritis/Ulcers	Bowel Problems	Cardiac Disease
Lung/Breathing Difficulties	High Blood Pressure	High Cholesterol
Diabetes (insulin vs. non-insulin)	Thyroid Disease	Stroke
Osteoarthritis	Rheumatoid Arthritis	Osteoporosis
Neurologic Disease/Seizures	Blood Transfusions	Cancer (type and when) _______

Other conditions (please list): ____

Reviewing Doctor/P.A. Signature: ______________________________ Date: _______

Patient name: ___________________________

CURRENT MEDICATIONS: Please any current medications and dosages.

____

____

____

____

____

Do you have any allergies to medications? NO YES (please list): ______________________________

Are you allergic to latex? NO YES (please list reaction) ______________________________

Please list any prior surgeries and/or hospitalizations and year they occurred:

____

____

____

____

Family History:

Please list any medical problems of members in your family:

Grandparents: ______________________________

Father: ______________________________ Mother: ______________________________

Brothers: ______________________________ Sisters: ______________________________

Social History:

Are you currently employed? YES NO

Current Occupation: ______________________________

If NO are you (please circle): Retired SS/Disability Workman's Comp Unemployed

Do you currently smoke? NO YES If yes: How many packs per day? _____ How many years have you smoked? _____

Have you ever smoked in the past and quit? If so how many packs per day? _____ How long ago did you quit? _____

How often do you drink alcohol? (please circle): Never 1-2 times per month 1-2 times per week Daily

Do you use any illicit drugs (ex. Marijuana/Cocaine)? ______________________________

Any history of alcohol/drug/pain pill abuse? NO YES (If so what and when?) ______________________________

Highest level of education reached (please circle):

High School/GED Associate's Degree Bachelor's Degree Graduate Degree Other: ____________________

Reviewing Doctor/P.A. Signature: ______________________________ Date: ____________________