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****DEMOGRAPHICS****

DATE: _____

PATIENT NAME: (please print) _____ DATE OF BIRTH: _____

MALE_____ FEMALE_____

LOCAL ADDRESS: _____ APT #_____

CITY: _____ ST: _____ ZIP CODE_____

MAILING ADDRESS: _____

CITY: _____ ST: _____ ZIP CODE: _____

HOME #: _____ CELL#: _____

**PREFERRED PHONE#: _____

EMAIL ADDRESS: (for appt reminders or E-Statements)

_____

EMPLOYERS NAME: _____ OCCUPATION: _____

IS TODAY'S VISIT DUE TO AN ACCIDENT? _____ NO _____YES IF YES, DATE OF ACCIDENT_____

AUTO OR WORK RELATED? _____ AUTO _____WORK

IF OTHER PLEASE EXPLAIN_____

***EMERGENCY CONTACT *** _____ **PHONE:** _____ **RELATIONSHIP**_____

PRIMARY HEALTH INSURANCE: _____ID: _____

SECONDARY INSURANCE: _____ ID: _____

PRIMARY CARE PHYSICIAN _____ PHONE #: _____

PHARMACY NAME: _____PHONE # _____

PHARMACY
ADDRESS_____

HOW DID YOU HEAR ABOUT US:

_____

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Please complete this section if you would like us to release your protected health information to specific family members or care givers.

I authorize Freedom Orthopaedics to disclose medical information to the following people:

Name: _____ Relationship to you: _____
Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____
Name: _____ Relationship to you: _____

I authorize Freedom Orthopedics to release my medical information for the purpose of processing insurance claims, insurance applications, filling prescriptions, fulfilling prior authorization requirements as defined by my insurance company for advanced imaging studies/ scheduled procedures, to a hospital or facility at which I am having a medical procedure, and to my primary care doctor or referring physician, or other medical providers who require this information for my continuation of care.

I have the right to revoke this consent in writing at any time. The revocation will be void in the instance that Freedom Orthopaedics, LLC has acted in reliance on this consent.

Signature: _____ Date: _____

FINANCIAL POLICY

Our goal is to provide and maintain a good physician/patient relationship between you and our office. Letting you know of our policies in advance allows for open communication and for you to make an informed decision regarding your care.

Please read the following, if you have any questions, see the front desk.

- It is the policy of Freedom Orthopaedics that payment is due at the time of service.
- We require all patients to pay their copayment, coinsurance, and/ or deductible requirements at the beginning of each visit. If you receive any additional services or products that were not anticipated prior to you seeing the doctor (supplements, injections, durable medical equipment, etc.) the staff will let you know if this will incur an out-of pocket cost and you may be expected to pay upon check out or you may receive a bill. We accept cash or credit cards.
- You understand that it is your responsibility to be knowledgeable about your health insurance policy and benefits. We will always bill your insurance company based on the contracted rate we have with that carrier. We do not control these rates or values and are unable to change them due to our contractual obligation with your insurance company.
- You understand it is your responsibility to keep your information on file up to date. If you change insurance policies, move to a new address, or acquire a new phone number it is imperative that you notify our office. Failure to update your information with our office can result in outstanding balances. We will make every effort to contact you by mail to make you aware of your balance. Balances outstanding for greater than 90 days, with no payments made towards the balance, will be sent to a collection agency at which point your balance will incur a collection fee.
  • Not all services are covered by individual insurance plan. We will make every effort to verify your insurance benefits and notify you of non- coverage accordingly. Should you elect to receive a service not covered by your insurance, you will be fully responsible for its cost.
  • Our office has a no-show policy for appointments. Any appointment not canceled within 24 hours of the appointment time will incur a $25 fee. We understand there are outstanding circumstances to this policy and all fees are reviewed on a case-by-case basis.
  • Our office accepts “self-pay” or “cash-pay” patients. We only offer this to patients who do not have insurance or hold an insurance policy that we do not participate with.

By signing this form, you agree to the financial policies. You acknowledge that you have received notice of these policies.

Print Name _____ Date: _____

Signature: _____

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MEDICAL HISTORY

Please briefly explain what brings you in today_____

_____

Do you have any medication allergies? ____ Yes ____No If yes, please list: _____

Please select any of the following conditions that pertain to you

Anxiety: _____	Heart Disease_____	Hepatitis: _____	Pacemaker: _____
Anemia: _____	Chronic Pain_____	HIV/AIDS: _____	Pulmonary Embolism: ___
Asthma: _____	COPD: _____	High Blood Pressure: _____	Radiation Therapy: _____
Atrial Fibrillation: _____	Coronary Artery Disease_____	Hyperthyroid: _____	Rheumatoid Arthritis: ____
Bipolar Disorder: _____	Deep Vein Thrombosis: _____	Kidney Disease: _____	Sleep Apnea_____
Cancer: _____	Depression: _____	Multiple Myeloma: _____	Seizures: _____
High Cholesterol_____	Diabetes_____	Obesity: _____	Stroke: _____

Other:

_____

Surgical History (please list procedure and date)

_____

_____

SOCIAL HISTORY

Do you smoke? _____ Yes _____No If yes, how much? _____

Do you drink? ____ Yes _____No If yes, how often/much? _____

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Please indicate if you have experienced any of the following symptoms in the last 6 months.

If none apply, check here _____

Weight Loss_____	Fatigue_____	Loss of Appetite_____
Blurred Vision_____	Double Vision_____	Vision Loss_____
Hearing Loss_____	Hoarseness_____	Trouble Swallowing_____
Chest Pain_____	Palpitations_____	
Chronic Cough_____	Pneumonia_____	Shortness of Breath_____
Heartburn_____	Nausea, Vomiting_____	Blood in Stool_____
Painful Urination_____	Blood in Urine_____	Kidney Problems_____
Frequent Rashes_____	Skin Ulcers/Lesions_____	Psoriasis_____
Frequent Falls_____	Loss of balance/coordination_____	Numbness_____
Change in Bowel_____	Change in Bladder_____	Dizziness_____
Depression/ Anxiety	Drug/Alcohol Addiction_____	Sleep Disorder_____
Fever_____	Heat or Cold Intolerance_____	Night Sweats_____
Easy Bleeding_____	Easy Bruining_____	Anemia_____