TENNESSEE ORTHOPAEDIC ALLIANCE

For Office Use Only: Date:__________________ Account #________________ ☐ New ☐ Update

Patient's Legal Name:
Last: First: Middle:

Previous Last:

Social Security: | **Birthdate:** | **Sex:**

Billing Address: (Please do not use a PO Box number) ☐ Current ☐ Home ☐ Work ☐ Mailing
Street: Apt.# City: State: Zip:

Secondary Address: (Please do not use a PO Box number) ☐ Current ☐ Home ☐ Work ☐ Mailing
Street: Apt.# City: State: Zip:

Race* ☐ White* ☐ Asian* ☐ Black/African Am.* ☐ Native Am.* ☐ Pacific* ☐ Other* ☐ Decline*
Language* ☐ English* ☐ Spanish* ☐ Other* ☐ Decline*
Ethnicity* ☐ Not Latino* ☐ Latino* ☐ Unknown* ☐ Decline* ***Required by Federal Government***

Marital Status: | **Student Status:** | **Family or Primary Care Physician:**

Home Phone: *(Include Area Code)*
( )
Day Phone: *(Include Area Code)*
Alternate Phone: *(Include Area Code)*

Cell Phone: *(Include Area Code)*
( )
Email:

Patient Employer (or school): | **Patient Occupation:**

Spouse's Name: | **Spouse's Social Security:** | **Spouse's Date of Birth:** | **Spouse's Daytime Phone:**

Emergency Contact: *(Not living in Same Household)*
Contact's Phone: *(Include Area Code):*
( )

Emergency Contact's Address:
Street: Apt.# City: State: Zip:

Contact's Relationship to Patient:

IF PATIENT IS RESPONSIBLE FOR ALL AMOUNTS DUE, PLEASE SKIP TO INSURANCE SECTION

Name of Responsible Party for Payment
Last: First: Middle Initial:
Social Security #:

Responsible Party's Relationship to Patient:
☐ Parent ☐ Spouse ☐ Legal Guardian
☐ Other (specify):______________________________

Sex:
☐ Female
☐ Male

Date of Birth:

Marital Status:
☐ Married ☐ Single
☐ Divorced ☐ Widowed

Address of Responsible Party:
Street: Apt.# City: State: Zip:

Responsible Party Home Phone *(Include Area Code)*
( )
Responsible Party Work Phone *(Include Area Code)*
( )

☐ **PRIMARY INSURANCE**
High-deductible plan? ☐ Yes ☐ No
Insurance Company Name:
Insured's Employer:

Subscriber ID: **Group ID:**

Policy Holder's Information: Patient's Relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other
Name: Birthdate: Social Security #: Sex:

☐ **SECONDARY INSURANCE**
High-deductible plan? ☐ Yes ☐ No
Insurance Company Name:
Insured's Employer:

Subscriber ID: **Group ID:**

Policy Holder's Information: Patient's Relation to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other
Name: Birthdate: Social Security #: Sex:

I acknowledge that all of the above information is correct. I hereby authorize TOA physicians and staff to perform upon me or the above named patient any examination(s), x-rays, and/or tests required for treatment of my orthopaedic illness or injury.

DATE:_________________________ **PATIENT/PARENT/GUARDIAN:**____

Patient______________________ **Tennessee Orthopaedic Alliance** Date__________________

Your personal Information ***PI***

Age ________ I prefer to be called __________________ Who referred you to our office?__________________________

Employer ___________________________ Occupation_________________________ Education level___________________

School, if a student_______________________________ Grade__________________ Current sport___________________

Additional information about you ****Required by Federal Government*** ***SH****

Height *_____________ Weight *_______________ Handed ☐ Right ☐ Left

Tobacco* ☐ Current every day smoker* ☐ Smoker, no details* ☐ Former smoker*

☐ Current some day smoker* ☐ Never smoker* ☐ Decline*

If current or past smoker: Packs per day________ Years of smoking:________

Alcohol use ☐ None ☐ Rarely ☐ Socially ☐ Daily

Recreational drug use ☐ None ☐ Rarely ☐ Socially ☐ Daily

Your ORTHOPAEDIC problem today ***HPI***

Part(s) of your body____ ☐ Right ☐ Left

Describe your problem____

____

Injury or onset date _______________ Date first treated__________________ ☐ This was an injury

☐ Motor vehicle accident ☐ Sports_______________________ ☐ Other ______________________________

☐ Work-related ☐ A lawyer is involved ☐ A lawyer will be involved

Tests done already ☐ Xrays ☐ MRI ☐ CAT scan ☐ Other______________________________

Treatment ☐ Non-prescription meds ☐ Prescription meds ☐ Ice ☐ Injected ☐ Physical therapy

☐ Surgery ____ ☐ Other______________________________

Using the symbols below, mark on the body, hands, or feet where you feel the following:

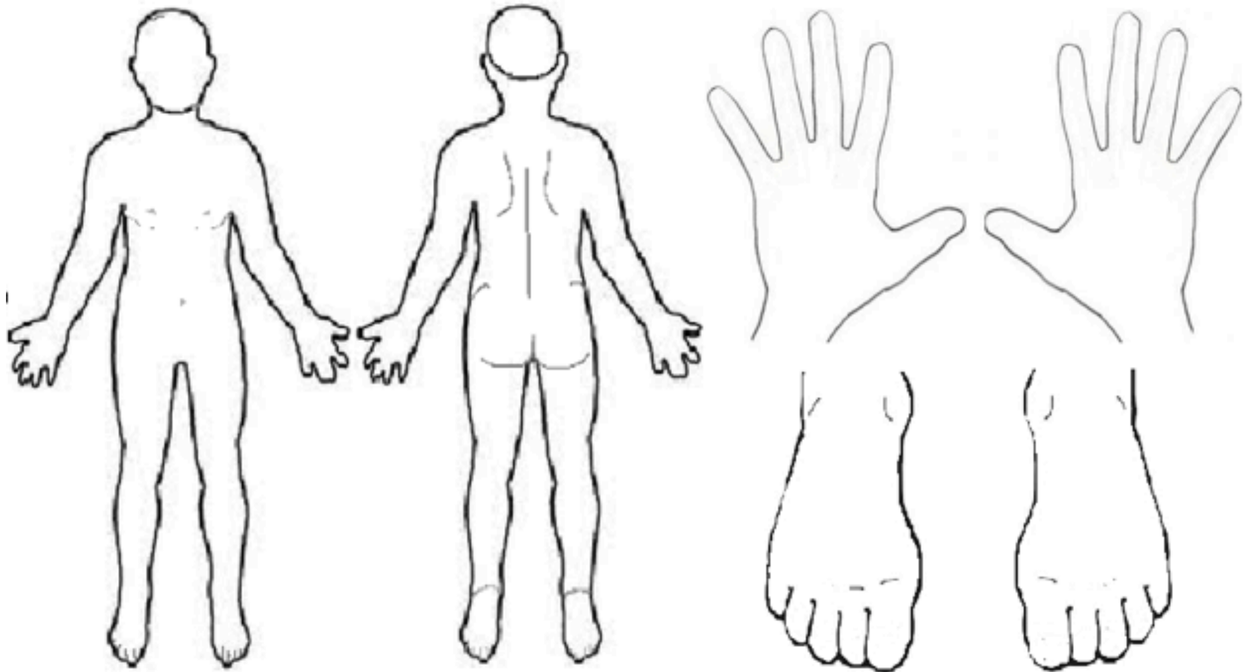
Numbness =====

Pins/Needles ooooo

Burning xxxxx

Stabbing /////

Aching +++++



Severity of pain	None	0	1	2	3	4	5	6	7	8	9	10	Severe
Functional limitation	None	0	1	2	3	4	5	6	7	8	9	10	Severe

Provider Initials_____________

Patient__________________________________ Date____________________

Special Alerts

☐ *I have none of the following conditions* **ALERTS**

☐ Blood thinners	☐ Kidney disease	☐ Pacemaker	☐ Sleep apnea
☐ Diabetes	☐ Liver disease	☐ Peptic ulcers	☐ Pregnant
☐ Jehovah's witness	☐ Previous MRSA	☐ Past phlebitis or embolism	

Your other medical conditions

☐ *No other medical conditions* **PMH**

☐ AIDS/HIV	☐ Heart failure	☐ Hiatal hernia/reflux	☐ Multiple sclerosis	☐ Scoliosis
☐ Alcoholism	☐ COPD/Emphysema	☐ Gout	☐ Heart attack	☐ Seizures
☐ Alzheimers	☐ Cardiac artery disease	☐ Hepatitis	☐ Osteoarthritis	☐ Lupus
☐ Anemia	☐ Crohn's disease	☐ Hyperlipidemia	☐ Osteoporosis	☐ Spinal stenosis
☐ Angina	☐ Degenerative joints	☐ High blood pressure	☐ Parkinson's	☐ Thyroid disease
☐ Arthritis	☐ Depression	☐ Inflam. bowel/Crohn's	☐ Psoriasis	☐ Heart valve dx
☐ Asthma	☐ Fibromyalgia	☐ Juvenile rheum. arth.	☐ Peripheral vasc. dx	
☐ Atrial fib	☐ Gallbladder disease	☐ Lyme disease	☐ Rheumatoid arth.	
☐ Cancer				
☐ Stroke				

Other ____

Your prior surgeries

☐ *No prior surgeries* **PMH**

Date	Date	Date	Date
☐ ACL surgery	☐ Back surgery	☐ Hernia repair	☐ Rotator cuff repair
☐ Angioplasty	☐ CABG/Heart bypass	☐ Hip arthroplasty	☐ Small bowel resection
☐ Angioplasty and stent	☐ Heart valve replaced	☐ Hip replacement	☐ Thyroidectomy
☐ Arthroscopy ankle	☐ Carpal tunnel release	☐ Knee replacement	☐ Tonsillectomy
☐ Arthroscopy elbow	☐ Gallbladder removal	☐ Laminectomy	☐ Hysterectomy
☐ Arthroscopy hip	☐ Colon removal	☐ Meniscus surgery	☐ Mastectomy
☐ Arthroscopy knee	☐ Colostomy	☐ Muscle biopsy	☐ Lumbar fusion
☐ Arthroscopy wrist	☐ Disc surgery	☐ Fracture surgery	☐ Cervical fusion
☐ Arthroscopy shoulder	☐ Gastric bypass		

Other ____

Other symptoms or complaints that you have

☐ *No other symptoms or complaints* **ROS**

☐ Chills	☐ Heart murmur	☐ Cold intolerant	☐ Contact allergy
☐ Fever	☐ Leg swelling	☐ Heat intolerant	☐ Itchy skin
☐ Night sweats	☐ Syncope or fainting	☐ Difficulty walking	☐ Rash
☐ Weakness	☐ Irregular heartbeat	☐ Dizziness	☐ Skin infections
☐ Weight loss	☐ Abdominal pain	☐ Poor coordination	☐ Skin lesion
☐ Blurred vision	☐ Constipation	☐ Memory loss	☐ Bleeding
☐ Headache	☐ Black tarry stools	☐ Muscle weakness	☐ Bruising
☐ Hearing loss	☐ Diarrhea	☐ Seizures	☐ Asthma
☐ Ringing in ears	☐ Loss of appetite	☐ Depression	
☐ Vertigo	☐ Nausea	☐ Insomnia	
☐ Vision loss	☐ Vomiting		
☐ Chest pain	☐ Painful urination		
☐ Cough	☐ Frequent urination		
☐ Shortness of breath	☐ Bloody urine		
☐ Recent infections	☐ Urinary incontinence		
☐ Known TB exposure			

Other ____

Provider Initials______________

Patient___________________________________ Date____________________

Your FAMILY'S medical history ☐ *No significant family medical history* **FH**

	Mother	Father	Brother	Sister
Deceased	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disease	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Colitis	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐
Muscle disease	☐	☐	☐	☐
Parkinson's	☐	☐	☐	☐
Peripheral vascular dx	☐	☐	☐	☐
Stroke	☐	☐	☐	☐

*Your MEDICATIONS**

☐ *No Medications* **MEDS***

Preferred Pharmacy:____ Phone:____________________

Medication Name*	Dosage (If known)	Times per Day (If known)

Medication Name*	Dosage (If known)	Times per Day (If known)

*Your ALLERGIES**

☐ *No Allergies* **ALLERGIES***

Medication Name*	Type of Reaction

Medication Name*	Type of Reaction

Provider Signature____

Office Use Only - This Page Patient________________________________ Date__________________

Nurse's Notes Height*________ Weight*_________ BP*______ / ______ ***NN****
Provider Notes:
Assessments (ICD-9 coding):
Medication prescriptions: ☐ ePrescribe if possible
Lab Tests:
Casts or Splints:
DME items:
Injections or Office Medications:
Follow-up (RTC) or Referral:
Work/School/Sports Restrictions and Instructions:
Office Procedures or Fracture Care:
Schedule Surgery:
Schedule MRI or other Imaging: ☐ TOA if possible
Schedule EMG/NCS or Vascular Studies:
Schedule PT/OT: ☐ TOA if possible

Provider Signature___________________________________

Patient Name ______________________________ Account Number __________________________

Patient Financial Responsibility

I acknowledge full financial responsibility for services rendered by Tennessee Orthopaedic Alliance. I understand that I am responsible for prompt payment of any amounts due including, but not limited to: co-pays, deductibles, and coinsurance amounts. I understand that payment of co-pays, deductibles and coinsurance amounts are expected at time of service, as well as any prior balances I may owe. I also consent that payment of authorized Medicare and any other insurance benefits may be made on my behalf directly to TOA for any medical and/or therapy, imaging, and/or surgical services furnished. I agree to be responsible for all reasonable attorney fees and collection costs in the event of default of payment of my charges, as outlined in office and financial policy guidelines.

Signed ____ Date__________________________________

Printed Name ____

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I authorize Tennessee Orthopaedic Alliance physicians and staff to render medical treatment and evaluation needed. I further authorize order of x-rays, injections, casting or other diagnostic tests and treatment that may be necessary to diagnose and treat my illness or injuries. I hereby give my consent to TOA to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all protected health information contained in the patient record of ____________________________________. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice. I also understand that I will not be able to revoke this consent in cases where my provider has referred to it for purposes of disclosing my health information. Written revocation of consent must be sent to the physician's office, Attn: Administration.

Signed ____ Date__________________________________

Printed Name ____

Acknowledgment – Notice of Privacy Practices

I hereby acknowledge receipt of TOA's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential protected health information. I have reviewed TOA's Notice of Privacy Practices. I understand that TOA reserves the right to change its privacy practices that are described in that Notice. I also understand that any Revised Notice will be posted on TOAs website, available at each office, or mailed upon request.

Signed ____ Date__________________________________

Printed Name ____

If you are not the patient, please specify your relationship to the patient _______________________________