



Please Fill Out Form and Click Submit at the Bottom of this Form to Send as an E-mail.

PATIENT INFORMATION

DATE:

Patient Name :	
Address :	
City :	
State :	
Zip Code :	
Home Phone :	
Mobile Phone :	
Business Phone :	
Date of Birth :	
Social Security # :	
Marital Status :	
Sex :	
Occupation :	

EMPLOYER INFORMATION

Employer Name :	
Employer Address :	
City :	
State :	
Zip Code :	
Employer Phone # :	



MEDICAL INFORMATION

Referring Doctor :	
Primary Doctor :	
Primary Insurance :	
Insurance ID :	
Policy Group # :	
Primary Insured's Name :	
Primary Insured's DOB :	
Secondary Insurance:	
Insurance ID :	
Secondary Insured's Name :	

MEDICAL QUESTIONNAIRE

What is the main reason for this visit?

Is this related to an injury? Yes No If yes, is it work related? Yes No

Is this injury due to a motor vehicle accident? Yes No

Please provide a brief description of the injury here,

Date of onset/injury? _____

What is your current work status? _____

When is the last date that you worked your regular job (if applicable) _____



ALLERGIES:

Are you ALLERGIC to any medications? Yes No

If yes, please list and describe the reaction

FAMILY HISTORY:

Have any direct relatives had any of the following disorders? If so, please identify which relative as follows: M = Mother, F = Father, B = Brother, S = Sister, C = Child

- | | |
|---|---|
| <input type="checkbox"/> Diabetes Mellitus (high sugar) _____ | <input type="checkbox"/> Rheumatoid Arthritis _____ |
| <input type="checkbox"/> Hypertension (high blood pressure) _____ | <input type="checkbox"/> Heart Disease / Disorder _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> None |

PAST MEDICAL HISTORY: Have you ever had:

- | | |
|--|--|
| <input type="checkbox"/> Allergic reaction to anesthesia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood clots (DVT) | <input type="checkbox"/> Cancer (type/location) _____ |
| <input type="checkbox"/> Diabetes Mellitus (high sugar) | <input type="checkbox"/> Heart Attack (year) _____ |
| <input type="checkbox"/> Insulin Dependent | <input type="checkbox"/> Heart Failure (CHF) |
| <input type="checkbox"/> Non-Insulin Dependent | <input type="checkbox"/> Hypertension(high blood pressure) |
| <input type="checkbox"/> Stomach Ulcer –Bleeding? Yes/No | <input type="checkbox"/> Kidney Failure |
| <input type="checkbox"/> Transfusion reaction (blood products) | <input type="checkbox"/> Stroke (CVA) |
- I do not have any of the above conditions

PAST SURGICAL HISTORY:

List any operations you have had. Please include the date of the surgery and the surgeon.

None



SOCIAL HISTORY:

Do you use tobacco? Yes No If yes, pack per day _____

Do you drink alcohol? Yes No If yes, how often _____

MEDICATIONS:

What medications do you take? None. Please list with dosage and frequency:

REVIEW OF SYSTEMS:

General: Fatigue Unexplained weight change Fever

Skin: Jaundiced Bruising Rash/Ulcers

Respiratory: TB Shortness of breath Chronic cough

Cardiovascular: Blood clots Chest Pain Palpitations

Gastrointestinal: Blood in stool Change in bowel habits Nausea/Vomiting
 Heartburn/Ulcers Stomachache with anti-inflammatory meds

Musculoskeletal: Stiffness Joint pain Swelling Weakness
 Impaired range of motion Same orthopedic problem in the past

Neurological: Sensory Deficit Tingling Numbness Headaches
 Seizures

Psychiatric: Anxiety/Nervousness Depression Insomnia

Endocrine: Heat/Cold Intolerance Thyroid Disease

Hematology: Blood disorders Anemia Easy bruising/bleeding

The information on these forms is accurate to the best of my knowledge.

Signature

Date



REFERRAL INFORMATION:

Who were you referred by:

a) Relative _____

b) Friend _____

c) Physician _____

Name: _____

Address: _____

Phone #: _____

d) Attorney: _____

Name: _____

Address: _____

Phone #: _____

e) Other: _____

EMERGENCY CONTACT(S):

Name: _____

Address: _____

Phone #: _____

Name: _____

Address: _____

Phone #: _____



FINANCIAL POLICY

We thank you for choosing us as your orthopedic specialist. We at Southeastern Orthopedics are committed to your treatment being successful. Listed below please find the statement of our Financial Policy which we require you to read completely and sign prior to any medical services being rendered.

1. *WE WILL FILE YOUR INSURANCE FOR YOU. IF YOU DO NOT HAVE INSURANCE WE EXPECT FULL PAYMENT AT THE TIME OF SERVICE.*
2. *WE ACCEPT CASH, PERSONAL CHECKS, VISA & MASTERCARD. WE DO NOT ACCEPT POST-DATED CHECKS.*

INSURANCE

As a courtesy to you, we will gladly file your insurance if we are provided with accurate information. Please remember that you are responsible for whatever charges your insurance does not cover.

If you have surgery or fracture care, we expect you to pay any deductible not met or co-insurance you are responsible for. Bills for surgery will not include charges for anesthesia, hospitalization or laboratory tests. These are billed separately, from the facility where they are performed.

Please be aware that some services provided may be non-covered services or not considered medically necessary under Medicare and/or other medical insurance programs. If we are a participating provider with your insurance plan, all co-payments are due at the time of service. If we are not a participating provider with your insurance plan, you are responsible for the out-of-network rates at the time of service.

If you have been involved in an automobile accident or have any pending legal action, we will ask you to pay for services personally or through your health insurance. **WE DO NOT FILE THIRD PARTY INSURANCE AND WE DO NOT WAIT UNTIL SETTLEMENT FOR PAYMENT.**

IF PATIENT IS A MINOR

An adult parent or guardian accompanying the minor is responsible for the payment of the patient's account regardless of who the insurance policyholder is. Unaccompanied minors can be denied non-emergency treatment until a parent or guardian is present or we receive written permission for the treatment and payment of the account.

WE THANK YOU FOR UNDERSTANDING THE NECESSITY OF THE FINANCIAL POLICY. IF YOU SHOULD NEED TO MAKE SPECIAL PAYMENT ARRANGEMENTS, PLEASE BRING THIS TO OUR ATTENTION PRIOR TO EXAMINATION AND WE WILL ACCOMODATE YOU AS BEST AS WE CAN.

I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY:

Signature of patient (or guardian)

Date