CHESTERTOWN ORTHOPEDICS

Patient Information Sheet

Patient Name: _____ _____ _____

Last First M.I.

Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Alternate Phone Number: _____

Employer: _____ Employer Phone Number _____

DOB: ____/____/____ Age: _____ Gender: M F Marital Status: M S D W

Email: _____ Preferred Method of Communication: _____

Emergency Contact: _____ Phone: _____

Primary Physician: _____ Referring Physician: _____

Medical History:

Date of Symptoms/Injury: _____ (Where injured, When & How) _____

Reason for visit: (Circle) **Left or Right** Body Part: _____

X-rays: Y N Date____/____/____ ER: Y N Date: ____/____/____ MRI Scan: Y N Date: ___/___/___

In Which Hospital ER where you seen? _____

Insurance Information:

Primary Insurance: _____

Policy Holder: _____

Relationship to Policy Holder: _____ DOB: _____

ID#: _____ Group#: _____

Secondary Insurance: _____

Policy Holder: _____

Relationship to Policy Holder: _____ DOB: _____

ID# _____ Group #: _____

* If your visit is going through workers' compensation, auto insurance or any other type of insurance, please let the receptionist know so that we can get all necessary information from you to bill the proper company.

MEDICATION/ALLERGY LIST

Patient's Name:_____

DOB:_____DATE:_____

Pharmacy Name & Phone #: _____

List all medications including prescriptions, non-prescriptions, vitamins & herbal supplements.

Medications	Prescribing Physician	Dosage	Frequency

List any allergies to medications:_____

_____

Medical History

The following is very important to your health. Please take the time to fully and completely fill out this important information.

Last Name: _____First Name: _____

Social History:
Do you smoke? Yes____No____ No. packs/day____
Have you ever used tobacco? Yes_____No____ Quit when? _____
Do you drink alcohol? Yes_____No_____ Yrs./Quit_____

Patient's history of other illness/injury:

High Blood Pressure_____
Diabetes _____
Peptic Ulcers _____
Hepatitis _____
Gall Stones _____
Kidney Stones _____
Abdominal Bleeding _____
Accidents/Fractures _____
Sleep Apnea _____
Other (list) _____

Yellow Jaundice _____
Thyroid Problem _____
Lung Problems _____
Cancer _____
Heart Disease _____
Stroke _____
Arthritis _____
Diverticulosis _____
Kidney Failure _____

Family History of Illness:
Please Check if they apply and indicate family member.
Cancer _____ _____
Heart Disease _____ _____
Stroke _____ _____
Arthritis _____ _____

Previous Surgeries: (List names and dates of all operations you have had. _____None
Year Type of Surgery
_____ _____
_____ _____
_____ _____
List any hospital admissions or medical conditions not listed above:

Females only: Are you pregnant? _____ Yes _____No

The above information is true and correct to be best of my belief:

Patient Signature (parent if patient is a minor) _____Date_____

CHESTERTOWN ORTHOPEDICS & SPORTS MEDICINE
A Division of The Centers For Advanced Orthopaedics

Specializing in Arthroscopic Surgeries, Joints, Bones and Muscles
Physical Therapy, Pain Management & Rehabilitiation
Board Certified Orthopedic Surgeon
Licensed Physical Therapist

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1. **Co-Pays are due at the time of services**: I understand and agree that (regardless of my insurance status) that I am ultimately responsible for the balance of my account for any professional services rendered. I authorize the release of any medical information necessary to process my claim. I have furnished the above information and certify that it is true and correct to the best of my knowledge. I will notify Chestertown Orthopedics of any change in my health status and/or information above. As a courtesy, we can supply you with a computerized bill for your records upon request. There is a fee for completion of any additional insurance forms that must be processed by our office. *I agree to pay for services and/or supplies received if such services and/or supplies are denied by my insurance company/carrier.*

2. **Release of information:** All records concerning the patient's treatment remain the property of Chestertown Orthopedics, although the patient may obtain a copy by making a written request. As a condition of the patient receiving medical care at Chestertown Orthopedics, the undersigned consents to the use and disclosure of health information about the patient, including any other health care providers (i) in order to carry out that care and treatment of the patient, (ii) to the extent necessary to determine liability for payment and to obtain reimbursement, and (iii) for Chestertown Orthopedics internal health care operation, such as quality improvement, risk management, credentialing, peer review, business management, etc.

3. **Medicare or Medicaid Benefits:** I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I request the payment of authorized Medicare benefits. I authorize a holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I understand that Medicare will pay only for services which they determine to be reasonable and necessary under Section 1862(a) (1) of the Medicare Law. If Medicare denies payment for some or all of these services, *I agree to pay for them.*

The undersigned certifies that he/she has read and understands the foregoing, and is the patient or is duly authorized to act on behalf of the patient.

Acknowledgement of Privacy Practices

I acknowledge receipt of Chestertown Orthopedics Notice of Privacy Practices for Protected Health Information.

Signature: _____ **Date:** _____

Printed Name: _____ **Witness:** _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

Name of Patient (print):_____ Date of Birth:_____

I acknowledge that I have received a copy of the Notice of Privacy Practices (the "Notice") for Centers for Advanced Orthopaedics, LLC.

Signature: _____

(Patient or personal representative with appropriate legal authority)

Date: _____

Electronic Notice: If you would like to receive updates or changes to the Notice electronically, please provide your personal email address: _____. You will also be able to receive paper copies of the current notice upon request.

If signed by a Personal Representative:

Print Name: _____

Relationship to Patient: _____

(Parent, guardian, etc.)

--Office Use only—

If the patient has a personal representative with legal authority to make health care decisions on the Patient's behalf, the Notice must be given to, and acknowledgement obtained from, the Personal Representative. ***If the patient or Personal Representative did not sign above, document when and how the Notice was given to the Patient or Personal Representative and why the signed acknowledgement could not be obtained.***

Notice of Privacy Practices given to the individual on _____ (Date) by:

- ☐ Face to Face Meeting
- ☐ Mailing
- ☐ Email
- ☐ Other: _____

Reason Individual or Personal Representative did not sign the form:

- ☐ Patient or Personal Representative chose not to sign
- ☐ Patient or Personal Representative did not respond after more than one attempt
- ☐ Email receipt verification
- ☐ Other: _____