WELCOME TO PROVIDENCE BIRMINGHAM ORTHOPAEDICS & SPORTS MEDICINE

DATE: _____

YOUR NAME: (Last) _____ (First) _____ (Middle) _____

HOME ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: (Home) _____ (Cell) _____ (Work) _____

EMAIL: _____

BIRTHDATE: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

SEX: ☐ Male ☐ Female MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

RACE: _____ LANGUAGE: _____ ETHNICITY: _____

OCCUPATION: _____ SOCIAL SECURITY NO: _____

EMPLOYER: _____

EMPLOYER'S ADDRESS: _____ CITY/STATE/ZIP: _____

SPOUSE: _____ BIRTHDATE: _____ AGE: _____

SPOUSE'S EMPLOYER: _____ SOCIAL SECURITY NO: _____

EMPLOYER'S ADDRESS: _____

IN CASE OF EMERGENCY, CONTACT: _____ **RELATIONSHIP:** _____

HOME PHONE: (____) _____ **WORK PHONE:** (____) _____

WHO REFERRED YOU TO US? _____

REFERRING PHYSICIAN: _____ **PRIMARY PHYSICIAN** _____

ADDRESS: _____ **ADDRESS:** _____

CITY/STATE/ZIP: _____ **CITY/STATE/ZIP:** _____

PHONE: (____) _____ **PHONE:** (____) _____

MAY WE RELEASE MEDICAL INFORMATION TO YOUR PRIMARY PHYSICIAN? YES ☐ **NO** ☐

INSURANCE INFORMATION

PLEASE GIVE YOUR CARD TO THE RECEPTIONIST TO COPY

PRIMARY INSURANCE:

NAME OF INSURANCE CO: _____ POLICY HOLDER'S SS# _____

POLICY HOLDER: _____ BIRTHDATE: _____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE:

NAME OF INSURANCE CO: _____ POLICY HOLDER'S SS# _____

POLICY HOLDER: _____ BIRTHDATE: _____ RELATIONSHIP TO PATIENT _____

ASSIGNMENT AND RELEASE

- I hereby assign my insurance benefits to be paid directly to the physician
- I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize the physician to release any medical information required to process this claim.
- I authorize my provider's office to contact me by telephone to remind me of my appointments.
- A fee for no shows may apply.
- I authorize St. John Providence Health System to download my current medications for purposes of insurance payment.
- I have received a Notice of Privacy Practice, Notice of Patient Rights and Responsibilities, and Notice of Financial Policy.

SIGNATURE: _____ **DATE:** _____

BIRMINGHAM ORTHOPAEDICS & SPORTS MEDICINE, PLLC

DATE: _____

PATIENT NAME _____

REASON FOR APPOINTMENT:

_____

_____

_____

WHAT BODY PART? _____ ☐RIGHT ☐LEFT

DID YOU BRING X-RAYS WITH YOU TODAY? ☐YES ☐NO

ONSET DATE (if injury, see below): _____

DATE LAST WORKED: _____

INJURIES AND ACCIDENTS:

DATE OF INJURY: _____

WERE YOU INJURED AT WORK? ☐YES ☐NO

DATE LAST WORKED: _____

IN AN AUTO ACCIDENT? ☐YES ☐NO

IS AN ATTORNEY INVOLVED? ☐YES ☐NO

ATTORNEY'S NAME: _____

PHONE: (___) _____

EXPLAIN IN YOUR OWN WORDS HOW THIS INJURY OCCURRED:

_____

_____

_____

WHAT TREATMENT HAVE YOU HAD?

_____

_____

_____

PLEASE TELL US ABOUT YOURSELF AND YOUR MEDICAL HISTORY:

NAME: _____

DATE: _____

What are your **allergies**? (circle all that apply)

- ☐ NONE
- ☐ Penicillin
- ☐ Sulfa
- ☐ Morphine
- ☐ Codeine
- ☐ Iodine/Betadine
- ☐ Radiographic dyes
- ☐ Adhesive tape
- ☐ Latex
- ☐ Other (specify) _____
- ☐ Other (specify) _____
- ☐ Other (specify) _____

What **medicines** are you currently taking? Please include both prescription and non-prescription medications.

Medications	Dose	# Times a Day

What Pharmacy would you like prescriptions sent to?

Pharmacy Name_____ Pharmacy phone _____

PAST SURGICAL HISTORY

SURGERY	REASON/YEAR	SURGERY	REASON/YEAR
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

MEDICAL HISTORY

Anxiety Disorder	☐	☐	Heart Murmur	☐	☐
Arthritis	☐	☐	Hiatal Hernia	☐	☐
Asthma	☐	☐	HIV or AIDS	☐	☐
Bleeding Disorder	☐	☐	High Cholesterol	☐	☐
Blood Clots	☐	☐	High Blood Pressure	☐	☐
Cancer	☐	☐	Kidney Disease	☐	☐
Coronary Artery Disease	☐	☐	Kidney Stones	☐	☐
Claustrophobic	☐	☐	Leg Foot Ulcers	☐	☐
Diabetes – Insulin	☐	☐	Liver Disease	☐	☐
Diabetes – Non Insulin	☐	☐	Osteoporosis	☐	☐
Dialysis	☐	☐	Polio	☐	☐
Diverticulitis	☐	☐	Pumonary Embolism	☐	☐
Fibromyalgia	☐	☐	Reflux or Ulcers	☐	☐
Gout	☐	☐	Stroke	☐	☐
Have Pacemaker	☐	☐	Tuberculosis	☐	☐
Heart Attack	☐	☐	Overactive Thyroid	☐	☐

Have you ever had problems with **anesthesia**? ☐ Yes (What was your reaction?_____) ☐ No

Any previous **broken bones** or orthopaedic procedures? ☐ Yes ☐ No Prior **Blood** transfusions? ☐ Yes ☐ No

NAME: _____

DATE: _____

SOCIAL HISTORY

Occupation: _____

Physical requirements of Job _____

Caffeine:

None ☐ Moderate ☐

Heavy ☐ # of cups/cans per day? _____

Alcohol:

No ☐ Recovering alcoholic ☐

Occasionally ☐ How many drinks per week? _____

Tobacco:

Yes ☐ No ☐

If not currently have you ever used tobacco?

Yes ☐ No ☐

Cigarettes _____packs per day

Chew _____/day

Cigars _____/day

Drugs:

Do you currently use recreational or street drugs?

Yes ☐ No ☐

If Yes List: _____

What **hobbies**, activities, or sports do you currently participate in? _____

What is your current exercise level? None ☐ Occasional ☐ Moderate ☐ High Level ☐

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother	Y/N	_____	☐Heart Disease ☐Hypertension ☐Osteoporosis ☐Stroke ☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐Diabetes ☐Genetic disease
Grandfather	Y/N	_____	☐Heart Disease ☐Hypertension ☐Osteoporosis ☐Stroke ☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐Diabetes ☐Genetic disease
Father	Y/N	_____	☐Heart Disease ☐Hypertension ☐Osteoporosis ☐Stroke ☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐Diabetes ☐Genetic disease
Mother	Y/N	_____	☐Heart Disease ☐Hypertension ☐Osteoporosis ☐Stroke ☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐Diabetes ☐Genetic disease
Brother/Sister	Y/N	_____	☐Heart Disease ☐Hypertension ☐Osteoporosis ☐Stroke ☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐Diabetes ☐Genetic disease
Brother/Sister	Y/N	_____	☐Heart Disease ☐Hypertension ☐Osteoporosis ☐Stroke ☐Alcoholism ☐Arthritis ☐Depression ☐Cancer ☐Diabetes ☐Genetic disease

ST JOHN PROVIDENCE

Financial Agreement

- Payment is due at the time of service. We accept cash, checks and credit (Visa and Mastercard).
- All co-payments, deductibles, and non-covered services must be paid in full at the time of service.
- Our office will submit claims to your insurance company *as a courtesy* service to you. ***It is your responsibility to know what services your insurance plan covers;*** we take no responsibility to know what your insurance plan covers. Services that we render that are not covered by your insurance plan are your responsibility. We emphasize, as your health care providers, that ***our relationship is with you, not your insurance company***.
- In accordance with National Coding Guidelines, charges may be applied to services rendered during regularly scheduled evening (5pm or later), weekend, or holiday office hours in addition to basic visit charges. These charges may be passed to the patient if insurance coverage does not cover this code.
- If your insurance plan involves managed care, please review your coverage. ***If you need services that require a referral, adequate planning is essential.*** Referrals must be authorized by the doctor and ***may be subject to physician network restrictions***. Authorization from your insurance plan for your referrals may take one or more weeks. Please be aware that we may be unable to accommodate same day requests for referrals. Upon receipt of a referral to a specialist or ancillary service, it is your responsibility to be aware what has been authorized. Subsequent visits, procedures, surgeries, and hospitalizations may require additional referrals. Failure to obtain necessary authorizations could lead to out of pocket expenses for you. We are happy to assist you in any way with your health insurance managed care plan; however, our experience has demonstrated that planning and adequate lead time is essential. Your knowledge of your plan's regulations and benefits as well as adequate planning will help avoid delays and denied claims.
- If your insurance company requires laboratory specimens to be sent to a specific lab, it is your responsibility to know what labs participate with your plan. Please make us aware of this information.
- If you are experiencing financial difficulties, please discuss this with the business office staff. We will gladly work with you to make payment arrangements. ***Accounts over 90 days past due may be referred to a collection agency and such accounts may be reported to a national credit agency. You agree that we may charge reasonable collection fees and attorney fees if we are forced to refer your past due account to a collection agency and/ or attorney.***
- No Show Appointments: If an appointment is made with one of our physicians and the patient fails to show up for the appointment and has not called to cancel/reschedule 24 hours prior to the appointment, there will be a $25.00 charge.
- As Failure to show for appointments is extremely disruptive to our practice and can interfere with other patient's access to care, patients with three or more no-shows may be dismissed from the practice.
- There may be a charge for the preparation and completion of forms beyond those associated with normal visits. Prior to completion, you will be informed if a fee will be assessed. There will also be a $5 initial charge for the transfer of medical records + $0.10 / page after that.
- Be advised that, as per CPT National Coding standards, addressing acute/active medical issues during a Wellness/Preventive visit may result in additional separate billing codes distinct from the wellness visit codes. This may result in additional charges that may not be covered by your insurance. ***Preventative and sick visits should be scheduled separately*** to minimize this risk.
- Visits may have to be rescheduled if you arrive later than your scheduled time.

Please be advised that during your first visit to our office in each calendar year we will obtain a new signed financial agreement from each patient. We sincerely appreciate your cooperation and are happy to assist you in any way we can.

I have read, understand, and accept the above statements.

Print Name of Patient _____

Patient Signature _____ Date _____