Physician Name: David R. Lionberger, M.D.

PATIENT DEMOGRAPHIC INFORMATION SHEET

Last Name | First Name | Middle | Social Security No.

Date of Birth | Age | Male or Female (Please circle one) | Marital Status: M S W D (Please circle one)

Home Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Contact Preference: (Please Check One) Home Work Cell Mail Email Address

Referred By: Phone #:

EMERGENCY CONTACT INFORMATION

Name | Phone No. | Alt. Phone | Relationship

PATIENT EMPLOYER INFORMATION

Employer Name | Phone | Fax

Address | City | State | Zip

GUARANTOR / POLICY HOLDER INFORMATION

Last Name | First Name | Middle | Social Security No.

Date of Birth | Patient's Relationship to Policy Holder | Home Phone | Cell Phone

Employer Name | Phone | Fax

Employer Address | City | State | Zip

INSURANCE INFORMATION

Primary Insurance	Name of Primary Insurance	ID/Policy Number	Group Number	Customer Service No.
Secondary Insurance	Name of Secondary Insurance	ID/Policy Number	Group Number	Customer Service No.
Work Comp Insurance	Name of WC Insurance	Claim #	Adjuster Name	Adjuster Phone No.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT RELEASE ME FROM MY PERSONAL RESPONSIBILITY FOR PAYMENT OF ALL CHARGES WITHIN 50 DAYS. **AUTHORIZATION TO RELEASE INFORMATION:** I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OF TREATMENT.

Signature: **Date:**

DAVID R. LIONBERGER, M.D.

ORTHOPEDIC SURGEON
SOUTHWEST ORTHOPEDIC GROUP

(PLEASE FILL OUT COMPLETELY INCLUDING BACK SIDE OF THIS SHEET)

Date:	
Name:	
Date of Birth:	Age:
Height & Weight:	
Primary Care Doctor:	Phone #:
Referred by:	

Chief Complaint:

Describe in detail the reason for your visit include- **symptoms, location, onset, duration and severity**

_____

_____

_____

_____

_____

_____

Have you ever been treated with <u>injections</u> for <u>this extremity</u>? No ☐ Yes ☐

If yes, what type and when?_____

_____

_____

Have you ever had a <u>surgery</u> on <u>this extremity</u>? No ☐ Yes ☐

If yes, when? _____ Who was the surgeon?_____

Medication allergies and reaction:_____

_____

Please list <u>any other surgeries</u> and corresponding dates:_____

_____

_____

PATIENT HISTORY

PAST MEDICAL HISTORY
Please list all past and current medical problems/concerns:

General:

Fever No ☐ Yes ☐

Weight Loss/Gain No ☐ Yes ☐

Respiratory:

Chronic cough No ☐ Yes ☐

Difficulty breathing No ☐ Yes ☐

Cardiovascular:

Chest pain No ☐ Yes ☐

Shortness of breath No ☐ Yes ☐

Stroke No ☐ Yes ☐

High blood pressure No ☐ Yes ☐

Gastrointestinal:

Liver Problems No ☐ Yes ☐

Hepatitis **A/ B/ C** No ☐ Yes ☐

Stomach Ulcers No ☐ Yes ☐

Colitis No ☐ Yes ☐

Diabetes: No ☐ Yes ☐

Thyroid: (↑/↓) No ☐ Yes ☐

Cancer: No ☐ Yes ☐

What type?_____

When?_____

Treatment?_____

Musculoskeletal:

Weakness of muscles No ☐ Yes ☐

Osteoarthritis No ☐ Yes ☐

Rheumatoid Arthritis No ☐ Yes ☐

Radiating pain No ☐ Yes ☐

Scoliosis No ☐ Yes ☐

Gout No ☐ Yes ☐

Pain in calves/buttocks No ☐ Yes ☐

-Is pain relieved by rest? No ☐ Yes ☐

Use of:

Alcohol use No ☐ Yes ☐

How much? How often?_____

Smoking No ☐ Yes ☐

Packs per day?_____

Hematological:

Blood Clots No ☐ Yes ☐

Family history blood clots? No ☐ Yes ☐

Anemia No ☐ Yes ☐

Slow wound healing No ☐ Yes ☐

Lupus No ☐ Yes ☐

Other:_____

_____

Notes: Office Use Only

SOUTHWEST ORTHOPEDIC GROUP, LLP

Review of Notice of Privacy Practices

Acknowledgement:

I acknowledge that I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Patient or Personal Representative **Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____.

Financial Policy Statement

It is the policy of Southwest Orthopedic Group, LLP, to bill your insurance carrier as a courtesy to you; however, you are responsible for the entire bill. We require that arrangements for payment of your estimated share be made today. The insured/patient is responsible for any co-payments at the time service is rendered. If your insurance carrier does not remit payment within sixty (60) days, the balance will be due in full from you. If your insurance pays in excess of the balance of your account, we will refund the credit.

If any payment is made directly to you for services billed by Southwest Orthopedic Group, LLP, you recognize an obligation to promptly remit payment to Southwest Orthopedic Group, L.L.P.

The above does not apply to those patients that are considered Workers' Compensation. However, be advised as a Workers' Compensation patient that you may be held responsible for your charges in the event that your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Southwest Orthopedic Group, LLP, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

_____ _____

Responsible Party Print Name **Date**

_____

Responsible Party Signature

SOUTHWEST ORTHOPEDIC GROUP, L.L.P.

AUTHORIZATION FOR COMMUNICATION OF MEDICAL INFORMATION

Patient Name: _____ *DOB:* _____

Address: _____ *Telephone#*_____

In order for our practice to respond promptly and accurately to your needs, Please list any person(s) whom you would like to have access to your medical information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization is valid for 90 days from the date of my signature. I understand that this authorization authorizes the release of all my medical records. I further understand that I can revoke this authorization in writing at any time prior to the expiration date. In addition, I understand that any release of this information by the recipient without my further consent is prohibited. Finally, I understand that a photocopy of this authorization may be considered valid.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

Patient Name:_____ DOB:_____

Allergies: _____

Pharmacy Name: _____ Phone #: _____

Alt. Pharmacy Name: _____ Phone #: _____

PLEASE LIST **ALL** MEDICATIONS YOU ARE CURRENTLY TAKING ON A REGULAR BASIS INCLUDING **DOSAGE** AND **FREQUENCY**

Medication	Dosage	Times/day	Reason for taking this medication