Physician Name: Scott T. Orth, 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:

Scott T. Orth, M.D.

DATE: _____ NAME: _____

COMPLAINTS OR PROBLEM: _____ INDICATE: LEFT: _____ RIGHT: _____

WHEN DID PROBLEM BEGIN? _____

_____

_____

REFERRED BY: _____ FAMILY DOCTOR'S NAME: _____

ARE YOU IN GENERAL GOOD HEALTH AT THIS TIME? YES _____ NO _____ HEIGHT _____ WEIGHT _____

EXPLAIN ALL OTHER MEDICAL PROBLEMS: _____

_____

_____

LIST ALL OPERATIONS OF ANY TYPE AND YEAR OF SURGERY: _____

_____

_____

HAVE YOU HAD PROBLEMS WITH ANESTHESIA, INFECTION, BLEEDING, OR OTHER SURGICAL COMPLICATIONS?
YES _____ NO _____ EXPLAIN: _____

_____

HAVE YOU TAKEN MEDICINES FOR OR BEEN ON A DIET FOR: (CHECK YES OR NO)

	YES	NO		YES	NO		YES	NO
DIABETES	____	____	**STOMACH ULCERS**	____	____	**NERVOUS CONDITION**	____	____
HEART DISEASE	____	____	**DIVERICULITIS**	____	____	**BLADDER DISEASE**	____	____
KIDNEY DISEASE	____	____	**SEIZURES**	____	____	**HIGH BLOOD PRESSURE**	____	____
BLOOD THINNERS	____	____	**ASTHMA/EMPHYSEMA**	____	____	**HORMONES/BIRTH CONTROL**	____	____
ARTHRITIS	____	____	**HEP/LIVER PROBLEMS**	____	____	**HIV/AIDS/RECURRENT INF.**	____	____
THYROID DISEASE	____	____	**GLAUCOMA**	____	____	**CANCER**	____	____
CORTISONE	____	____	**LUPUS**	____	____	**RHEUMATOID ARTHRITIS**	____	____

LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING: _____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATION? YES ___ NO ___ IF SO CIRCLE OR LIST: PENICILLIN SULFA CODEINE DEMEROL NOVOCAINE _____

HAVE YOU EVER BROKEN ANY BONES OR WORN A BRACE OR CAST? _____

IS THERE A HISTORY IN YOUR BLOOD RELATIVES OF (CIRCLE): HEART DISEASE CANCER ABNORMAL BLEEDING CONGENITAL DISORDERS MUSCLE DISEASE LUPUS RHEUMATOID ARTHRITIS OTHER FAMILY DISORDERS _____

_____

ARE YOUR PARENTS LIVING? MOTHER YES ____ NO _____ DIED AT AGE _____ OF _____
FATHER YES ____ NO _____ DIED AT AGE _____ OF _____

DO YOU USE/SMOKE TOBACCO? YES ____ NO ____ HOW MUCH? _____ (PACKS PER DAY) FOR _____ YEARS.

PLEASE ESTIMATE YOUR ALCOHOL CONSUMPTION (CIRCLE): DON'T USE LIGHT OCCASIONAL/SOCIAL
MODERATE HEAVY OVERUSE

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