PATIENT DEMOGRAPHIC INFORMATION

DATE _____ DOB _____ SEX _____

FULL NAME:

_____

FIRST M.I. LAST

ADDRESS

_____

HOME PHONE # _____ CELLPHONE# _____

SSN _____ EMAIL _____

EMERGENCY CONTACT NAME: _____ PHONE # _____

EMERGENCY CONTACT RELATIONSHIP: _____

MEDICAL INFORMATION

REASON FOR VISIT _____ **LEFT / RIGHT**

DATE OF INJURY _____

PREVIOUS XRAYS? YES / NO (IF YES, WHAT FACILITY?) _____

IS THIS A WORK-RELATED INJURY? YES/ NO

IS THIS AN AUTO RELATED INJURY? YES / NO

PHARMACY: _____

LOCATION: _____

PHONE #: _____

PRIMARY CARE PHYSICIAN: _____

LOCATION: _____

ARE YOU UNDER THE CARE OF ANY OTHER SPECIALIST? NO / YES

(IF YES, WHO?) _____

Appalachian Orthopedics

MEDICAL INTAKE FORMS

NAME: _____

HEIGHT: _____ WEIGHT: _____

ALLERGIES: _____ LATEX: Y / N

CURRENT MEDICATIONS AND DOSAGES: (WRITE ON BACK IF NEEDED)

1)_____ 6) _____

2)_____ 7) _____

3)_____ 8) _____

4)_____ 9) _____

5)_____ 10) _____

FAMILY HISTORY

ALCOHOLISM: MOTHER / FATHER

ARTHRITIS: MOTHER / FATHER

BLEEDING DISORDER: MOTHER / FATHER

DIABETES: MOTHER / FATHER

GOUT: MOTHER / FATHER

HEART DISEASE: MOTHER / FATHER

HEPATITIS: MOTHER / FATHER

HIGH BLOOD PRESSURE: MOTHER / FATHER

KIDNEY DISEASE/STONES: MOTHER / FATHER

MENTAL ILLNESS: MOTHER / FATHER

SEIZURES: MOTHER / FATHER

STROKE: MOTHER / FATHER

TUBERCULOSIS: MOTHER / FATHER

SOCIAL HISTORY

DIET AND EXERCISE:

TYPE OF DIET: REGULAR / DIABETIC / CARDIAC

EXERCISE LEVEL: NONE / OCCASSIONAL / MODERATE

ACTIVITIES OF DAILY LIVING:

ARE YOU ABLE TO CARE FOR YOURSELF? YES / NO

DIFFICULTY SEEING? YES / NO

DIFFICULTY HEARING? YES / NO

DIFFICULTY MAKING DECISIONS? YES / NO

DIFFICULTY WALKING OR CLIMBING STAIRS? YES / NO

DIFFICULTY DRESSING OR BATHING? YES / NO

ABLE TO WALK? WITHOUT RESTRICTION / WITH ASSISTIVE DEVICES: CANE, WALKER, and/or CRUTCHES

DIFFICULTY WITH TRANSPORTATION? YES / NO

HAND DOMINANT: RIGHT / LEFT

EDUCATION AND OCCUPATION:

EMPLOYED: YES / NO

OCCUPATION: _____

SUBSTANCE USE:

HAVE YOU EVER USED TOBACCO? CURRENT USER / FORMER / NEVER

METHOD OF USE: SMOKE / VAPE / SMOKELESS TOBACCO

YEARS OF USE: _____

DRUG USE: YES / NO

ALCOHOL CONSUMPTION: YES / NO (OCCASIONAL OR MODERATE)

CAFFIENE USE: YES / NO (OCCASIONAL OR MODERATE)

MARITAL STATUS: MARRIED / SINGLE / DIVORCED / WIDOWED

DO YOU LIVE ALONE? YES / NO

DO YOU HAVE AN ADVANCED DIRECTIVE? YES/ NO

Appalachian Orthopedics

SURGICAL HISTORY

1)_____ 6) _____

2)_____ 7) _____

3)_____ 8) _____

4)_____ 9) _____

5)_____ 10) _____

PAST MEDICAL HISTORY

(CIRCLE ALL THAT APPLY)

ALLERGIES
ANEMIA
ANXIETY
ARRYTHMIA
ARTHRITIS
ASTHMA
BALANCE PROBLEMS
BLACKOUTS
BLADDER / KIDNEY ISSUES
BLEEDING DISORDER
BLOOD CLOTS
COPD
CANCER
CARPAL TUNNEL
COAGULATION DISORDER
CONGENITAL ABNORMALITIES
CORONARY ARTERY DISEASE
DEPRESSION
DEFIBRILLATOR
DIABETES
DIARRHEA
DIVERTICULITIS
EASY BRUISING
ECZEMA
EMPHYSEMA
FIBROMYALGIA
GERD / REFLUX
GALLSTONES
GLAUCOMA
GOUT
HIV / AIDS
HEAD TRAUMA
HEADACHES / MIGRAINES
HEART ATTACK
HEART PROBLEMS
HEPATITIS
HERNIA
HIGH BLOOD PRESSURE
HIGH CHOLESTEROL
HIVES
IRREGULAR HEARTBEAT
KIDNEY DISEASE
LIVER DISEASE
NEUROPATHY
NUMBNESS / TINGLING
OSTEOARTHRITIS
OSTEOPOROSIS
PACEMAKER
PANCREATITIS

Appalachian Orthopedics

PROSTATE	RHEUMATOID ARTHRITIS	STROKE
PULMONARY EMBOLISM	SEIZURES	THYROID
RASH	SHORTNESS OF BREATH	WEIGHTLOSS
SLEEP APNEA		

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

MUSCLE ACHES: Y / N

MUSCLE WEAKNESS: Y / N

JOINT PAIN: Y / N

BACK PAIN: Y / N

SWELLING OF EXTREMETIES: Y / N

Appalachian Orthopaedic Associates
Privacy Information

Certification of Receipt of Notice of Privacy Practices

I have received a copy of Appalachian Orthopaedic Associates' Notice of Privacy Practices for Protected Health Information.

Signature: _____ Date: _____

The patient was unable or unwilling to acknowledge receipt of the Notice of Privacy Practices for the following reason: _____

_____

Staff Name: _____ Date: _____

Signature: _____

_____

You have a right to restrict how we may communicate with you about your healthcare information. These questions will help us know how to get in touch with you about your health and appointment at this office.

How we may contact you:

1. May we contact you about your healthcare on your home phone? Y N
2. What phone number should we use? _____
3. May we leave a message on the answering machine? Y N
4. May we leave a message with adult family members at this number? Y N
5. May we give your spouse the same information we would give you? Y N
6. Who may receive information about your health, including information that you have an appointment or that it has been changed?

   _____

   _____

7. May we call in prescriptions to your pharmacy? Y N
8. What is the name and number of your pharmacy? _____

   _____

9. Who should be allowed to pick up a written prescription for you? _____

   _____

Do not discard this form.

03/13

Schedule A-2
APPALACHIAN ORTHOPEDIC ASSOCIATES
Payment Responsibility

Thank you for choosing Appalachian Orthopedic Associates as your orthopedic care provider. We are committed to providing you and your family with quality and affordable health care. In our ongoing process to make sure that all your medical needs are met, our staff will be available to discuss our fees and this policy.

All responsible parties must read our Payment Policy, complete patient information forms, and sign this Payment Responsibility Form prior to seeing a provider. Payments for your portion of all services will be due at the time services are rendered. Payment can be made online via our Patient Portal or in person at any of our locations. We accept cash, check, Visa, MasterCard, Discover, and CareCredit. Payments made with a CareCredit card cannot be processed online or via a tablet provided by our office, but rather must be brought to one of our front desk staff for processing.

1. I agree that my check may be used to make an electronic payment in the amount due from my account. Further, I agree that, should my check be returned for non-sufficient funds, I expressly authorize my account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. By using a check for payment, I am acknowledging and accepting these terms and conditions.

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

3. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement of any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to Appalachian Orthopedic Associates. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is my responsibility to pay any deductible amount, co-insurance or any other balance not paid for by my insurance. Additionally, should I be scheduled for elective surgery, I understand that I will be required to make payment on my responsibility prior to surgery.

4. I have read and understand Appalachian Orthopedic Associates's Payment policy and the above assignments. I will be responsible for the patient listed below.

Printed name of patient	Account Number
Signature of patient or responsible party	Date

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I do hereby authorize Appalachian Orthopaedic Associates and/or Appalachian Rehab & Sports Medicine to release my medical records to my insurance company or referring physician. I also authorize said insurance company to pay benefits directly to Appalachian Orthopaedic Associates and/or Appalachian Rehab & Sports Medicine, which includes any Medigap benefits. I understand that I am responsible for any balance not covered by insurance.

DOCTOR'S LIEN

I do hereby authorize Appalachian Orthopaedic Associates and/or Appalachian Rehab & Sports Medicine to furnish you, my attorney or insurance carrier, with a full report of my medical records. This can include my examination findings, diagnosis, treatment and prognosis in regards to this accident on _____.

I hereby give a lien to said doctor on any settlement, judgment or verdict as a result of said accident and authorize and direct you, my attorney or insurance carrier, to pay directly to said doctor such sums as may be due and owing him for services rendered to me; and to withhold such sums from such settlement, judgment or verdict as may be necessary to protect said doctor adequately.

I acknowledge full responsibility for the payment of services and agree to pay them in full at the time of service unless other arrangements are made with the financial department.

DATE:_____ SIGNED:_____

WITNESS:_____