Lincoln Orthopaedic Center
Dedicated Surgical Expertise

Date of Visit: _____
Patient #: _____
☐ New Patient ☐ Update

Patient Information

Name: Mr./Mrs./Ms. _____ (Last / First / Middle)
Address: _____
Age: _____ Birthdate: _____ Sex: M F Marital Status: Single / Married / Divorced / Widowed
Social Security No: _____ Primary Phone: _____ Secondary Phone: _____
Email Address: _____

Race:
☐ Asian ☐ Black/African American
☐ Caucasian/White ☐ Hispanic
☐ Multi-Racial ☐ Other _____
☐ Decline to Answer

Ethnicity:
☐ Hispanic Origin
☐ Non-Hispanic
☐ Decline to Answer

Language:
☐ English
☐ Spanish
☐ Other _____

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student
Employer: _____ Occupation: _____
Employer Address: _____
Spouse's Name: _____ Phone: _____
Spouse's Employer: _____
Spouse's Employer Address: _____
Name of Emergency Contact not living with you: _____
Relationship: _____ PrimaryPhone: _____ SecondaryPhone: _____
Who Referred You? _____ Family Doctor: _____

Medical Insurance Information

1) Primary Insurance: _____ Policy Holder Name: _____ DOB: _____
Policy Holder Address: _____ City _____ State ___ Zip _____
Relationship to Insured: _____ Policy ID #: _____ Group #: _____
Policy Holder's Social Security #: _____-_____-_____ Policy Holder's Employer _____
2) Secondary Insurance: _____ Policy Holder Name: _____ DOB: _____
Policy Holder Address: _____ City _____ State ___ Zip _____
Relationship to Insured: _____ Policy ID #: _____ Group #: _____
Policy Holder's Social Security #: _____-_____-_____ Policy Holder's Employer _____

Responsible Party (if patient is a minor)

Name: Mr./Mrs./Ms. _____ (Last / First / Middle)
Address: _____
Primary Phone: _____ Secondary Phone: _____
Employer: _____ Relationship to Patient: _____

Personal Health History

NAME_____ HEIGHT_____ WEIGHT_____

Surgeries and Hospitalizations:

Have you had any surgery or hospitalizations? ____Yes ____No **Dominant Hand:** ☐Right ☐Left

If Yes: (Please be specific as to the type of surgery, **body part, right or left**, year and Physician)

___Abdominal Surgery_____ Year_____ Physician_____

___Arthroscopy_____ Year_____ Physician_____

___Arthroscopy_____ Year_____ Physician_____

___Fracture_____ Year_____ Physician_____

___Fracture_____ Year_____ Physician_____

___Heart Surgery/ Procedure_____ Year_____ Physician_____

___Heart Surgery/ Procedure_____ Year_____ Physician_____

___Joint Replacement_____ Year_____ Physician_____

___Joint Replacement_____ Year_____ Physician_____

___Spine Surgery_____ Year_____ Physician_____

___Vascular/ Vein/ Artery_____ Year_____ Physician_____

___Other_____ Year_____ Physician_____

___Other_____ Year_____ Physician_____

___Other_____ Year_____ Physician_____

___Other_____ Year_____ Physician_____

___Other_____ Year_____ Physician_____

Do you have or have you had: (if YES check & explain)

☐ Anemia	☐ Diabetes	☐ Intestinal/ Bowel Problems	☐ Phlebitis
☐ Arthritis	☐ DVT/ Blood Clots	☐ Kidney Problems	☐ Polio
☐ Asthma	☐ Epilepsy	☐ Liver Disease	☐ Psychological Problems
☐ Birth Defects	☐ Gallbladder Problems	☐ Lung Problems	☐ Pulmonary Embolism
☐ Black Lung Disease	☐ Gout	☐ MRSA/ Staph Infection	☐ Rheumatic Fever
☐ Bladder Problems	☐ Heart Trouble	☐ Neurologic Disorder	☐ Sexually Transmitted Disease
☐ Bleeding Tendency	☐ Hepatitis	☐ Neuropathy	☐ Stroke/ TIA
☐ Blood Transfusion	☐ High Blood Pressure	☐ Osteoporosis	☐ Thyroid Problems
☐ Cancer	☐ High Cholesterol	☐ Pacemaker	☐ Tuberculosis
☐ Cortisone Drug	☐ HIV/ AIDS	☐ Peripheral Vascular Disease	☐ Ulcer (Type_____)
☐ Defibrillator			☐ None of these Apply

Explanation:_____

_____

Do you smoke? ☐ No ☐ Yes If yes, how many packs a day? ___Year Started?_____

☐ Former Smoker Year Started?_____ Year Quit?_____

Alcohol Use: ☐ No ☐ Yes If yes, please indicate amount and frequency _____

Recreational Drug Use: ☐ No ☐ Yes If yes, what & how often?_____

Please list any additional information you feel would be important to your treatment:

_____

_____

List ALL Medications you are now taking, including herbals and over the counter:

_____

_____

_____

Pharmacy Name & Address_____

Do you take Aspirin daily? ☐ No ☐ Yes _____

Do you take a blood thinning medication for ex. Coumadin? ☐ No ☐ Yes_____

Do you have any allergies to medications? ☐ No ☐ Yes

(If yes, please list them and the reaction you experienced)

_____

_____

_____

Do you have any non-medication allergies? ☐ No ☐ Yes Metal Allergy? ☐ No ☐ Yes

(If yes, please list them & the reaction that you experienced)

_____

_____

Do you have an allergy to LATEX? ☐ No ☐ Yes If yes, please describe your Reaction:_____

_____

Have you or anyone in your family **(Mother, Father, Sibling or Child)** ever had a reaction to any anesthetic, (general or local), causing malignant hyperthermia (high fever), blood pressure problems, or hepatitis?

"Yes" Please explain:_____

Do you know any blood relative (**Mother, Father, Sibling, or Child**) who has or had: (please check & give relationship)

☐ Alzheimer's_____
☐ Arthritis_____
☐ Bleeding Tendency_____
☐ Cancer_____
☐ Diabetes_____
☐ Gout_____
☐ Heart Disease_____
☐ Kidney Disease_____
☐ Osteoporosis_____
☐ Stroke_____
☐ Sudden Death_____
☐ Other_____

☐ *Unknown Family History*

**************PLEASE ANSWER ALL QUESTIONS BELOW REGARDING TODAY'S PROBLEM ONLY******************

1.What are we seeing you about today?_____

2. Date of injury, and/or when did you first notice symptoms? _____

3. What are those symptoms? _____

4. Where did the injury occur? (Home, work, church, etc) _____

5. How did the injury occur? _____

6. Did you have emergency room treatment? ☐ No ☐ Yes Treated Where?_____

7. Have you had an x-ray? ☐ No ☐ Yes If yes, where taken? _____

8. Have you had an MRI, CT ☐ No ☐ Yes If yes, please circle which one and where taken?_____

9. Have you had a Nerve Test (EMG/NCS)? ☐ No ☐ Yes If yes, by whom?_____

10. Have you had any Physical Therapy? ☐ No ☐ Yes If Yes, where?_____

11. Have you had any Cortisone Injections? ☐ No ☐ Yes If Yes, by whom?_____

Signature:_____ Date:_____

LOC Account #: _____

Review of Systems: **(Please check the following symptoms you have experienced on a regular basis or are being treated for by another provider)**

General
____ Fever
____ Weight change
____ Hormonal problems
____ Other _____
____ **NONE**

Cardiovascular
____ Chest Pain
____ Palpitations
____ Fluid/swelling in extremities
____ Pacemaker
____ Defibrillator
____ Other _____
____ **NONE**

Kidney/Bladder
____ Painful urination
____ Frequent urination
____ Incontinence
____ Other _____
____ **NONE**

Respiratory
____ Shortness of breath
____ Sleep apnea
____ Wheezing
____ Other _____
____ **NONE**

Eyes
____ Glasses/Contacts
____ Cataracts
____ Glaucoma
____ Other _____
____ **NONE**

Ears, Nose, Throat
____ Difficulty swallowing
____ Ear pain
____ Seasonal allergies
____ Hard of hearing
____ Other _____
____ **NONE**

Gastrointestinal
____ Heartburn
____ Diarrhea/Constipation
____ Abdominal pain
____ Nausea/Vomiting
____ Other _____
____ **NONE**

Hematologic/Lymphatic
____ Anemia
____ Blood problems
____ Clotting disorder
____ Lymph problems
____ Other _____
____ **NONE**

Psychological
____ Anxiety
____ Depression
____ Mood swings
____ Other _____
____ **NONE**

Neurological
____ Headaches
____ Numbness
____ Tingling
____ Seizures
____ Weakness
____ Other _____
____ **NONE**

Skin
____ Rashes
____ Lumps
____ Other _____
____ **NONE**

Patient Name: _____ **Date:** _____

Patient/Guardian Signature: _____ **Date:** _____

Provider: _____

LOC Account # _____

Patient Name: _____

Insurance Authorization and Assignment of Benefits:
I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process claims. I also authorize payment of medical benefits to Lincoln Orthopaedic Center PC for services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay. I agree to pay the cost of collection and/or court costs and reasonable fees should this be required.

I have read the above statements. It is my understanding that I am financially responsible to Lincoln Orthopaedic Center for the services provided to me or my dependent. I authorize my insurer to pay any benefits directly to Lincoln Orthopaedic Center. I agree to pay the full amount of all charges incurred by the above named patient that are not covered by my insurance carrier.

I agree that Lincoln Orthopaedic Center may request and use my prescription medication history from other healthcare provide4rs or third party pharmacy benefit payers for treatment purposes.

Patient Signature: _____ **Date:** _____

Guarantor Signature: _____ **Date:** _____
(if patient is a minor)

Medical Release: I hereby authorize Lincoln Orthopaedic Center to release my medical records to physicians, insurance carriers, and other social agencies as necessary. I also authorize Lincoln Orthopaedic Center to obtain any portion of my medical record from other institutions that is deemed medically necessary in the course of my treatment.
Patient/Guarantor Initials: _____

Consent to provide Treatment: I hereby authorize Lincoln Orthopaedic Center through its appropriate personnel to perform upon me or the above named patient, appropriate treatment procedures relating to my diagnosis.
Patient/Guarantor Initials: _____

RECEIPT OF NOTICE
OF PRIVACY PRACTICES

I have received a copy of Lincoln Orthopaedic Center PC's Notice of Privacy Practices which are effective September 23, 2013.

Printed Patient Name	**Patient Medical Record Number**
Signature	**Date**

Note: If signed by someone other than the patient, we need written proof of your authority.

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PERMISSION FOR VERBAL COMMUNICATIONS

Patient Name: _____ Date of Birth: _____

Medical Record No.: _____

I hereby expressly authorize Lincoln Orthopaedic Center to disclose or discuss my health and billing information, in person or by telephone, with the following individuals:

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The release of information under this Permission is limited to verbal communications between my Health Care Providers and the family members, other relatives, friends, and other persons identified above for the purpose of conveying information directly relevant to such person's involvement with my health care or payment related to my health care, as well as my location, general condition, and other limited information that, in the professional judgment of my Health Care Providers, is in my best interests.

<u>This document does not authorize the release of paper or electronic medical records.</u>

This Permission expires on _____. If no date is indicated, this Permission will remain in effect for twelve (12) months from the date of my signature, below.

Patient Signature: _____ Date: _____

Patient Name: _____