Starkville ORTHOPEDIC CLINIC

W. Todd Smith, M.D.

PATIENT INFORMATION

Patient Name_____

Last First MI

Mailing Address_____

Address City State Zip

Physical Address_____

Address City State Zip

Social Security #_____ Date of Birth_____ Male Female

Marital Status: Single Married Widowed Divorced

Home Phone_____ Cell Phone_____

Work Phone_____ Email Address_____

Employer_____ Occupation_____

Preferred Method of Appointment Reminders (circle one): Home Phone Text Message Email

EMERGENCY CONTACT (someone outside your home)

Name_____ Phone #: _____

GUARANTOR INFORMATION (Responsible Party)

Guarantor Name_____ Relationship_____

Mailing Address_____

Address City State Zip

Physical Address_____

Address City State Zip

Social Security #_____ **Date of Birth**_____

Employer_____ Work Phone_____

INSURANCE INFORMATION (copy of card must be provided)

Insurance_____ Policy #_____

Policy Holder Name _____

Policy Holder SS#_____ **Policy Holder Date of Birth**_____

I authorize medical treatment by Starkville Orthopedic Clinic. I assign all insurance payments to Starkville Orthopedic Clinic. I understand that any unpaid portion of charges for treatment not paid by my insurance company is my responsibility. I understand that if my balance is not paid in a timely manner and the account is referred for outside collections, I am responsible for any processing fees and/or court costs.

_____ _____

Signature (Guardian if patient is minor) Date

Starkville ORTHOPEDIC CLINIC

100 Wilburn Way, Starkville, MS 39759 (662) 320-4008

Patient Name_____ Date of Birth:_____

AUTHORIZATION FOR TREATMENT

I hereby authorize physicians, nurse practitioners, and/or staff to administer any medical, diagnostic, or therapeutic treatment as deemed necessary or advisable to me or the above referenced patient. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

ASSIGNMENT OF INSURANCE BENEFITS

Payment in full is due at the time services are rendered. I authorize direct payment of medical/surgical benefits to physicians and/or nurse practitioners of Starkville Orthopedic Clinic. I understand that my signature requests that payment be made and authorizes release of information necessary to pay the claim. I understand that I am financially responsible for any balance unpaid or not covered by my insurance company. I also understand that if any unpaid balance is forwarded to an outside collection agency for payment I will be responsible for any costs associated with resolution of the debt. I understand that if I fail to cancel my appointment 24 hours before my appointment time that I may be billed for an office visit.

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by physicians and/or nurse practitioners of Starkville Orthopedic Clinic and are accessible to office personnel. Starkville Orthopedic Clinic personnel may use and disclose medical information for operations, functions, and to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. Starkville Orthopedic Clinic and its' medical staff are authorized to disclose all or part of my medical record to any insurance carrier, worker's compensation carrier, or self-insured employer group liable for any part of Starkville Orthopedic Clinic charges and to any health care provider who is or may become involved in my care. Law requires that Starkville Orthopedic Clinic advise you that information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus, and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement you are consenting to such disclosure.

Certification: I hereby certify that I have read each of the above statements, have had each item explained to me, and have been offered a copy of the Patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as the original.

_____ _____

Patient Signature (or Legal Guardian) **Relationship to Patient**

_____ _____

Date Signed **Witness**

ACCIDENT QUESTIONNAIRE

Due to the nature of our practice, it is customary for your insurance carrier to send you a questionnaire to complete regarding the date, time, and location of your injury. Your visit may not be related to an injury. If you receive a questionnaire from your insurance company, it is imperative that you return the form to them immediately. Some insurance carriers will allow you to provide the information over the phone. Insurance companies will not process claims until you submit the form to them. Our office also gets a notification if your insurance has requested this information from you. All insurance carriers now have a very strict claim filing and processing deadline.

We can only hold your claim for 10 days from the date we receive notification before we transfer all charges to the patient. If you return the form to your insurance carrier, they will reprocess your claim.

By signing this statement, I acknowledge that I **will return any requested information to my insurance company and I will be liable for any charges if I fail to respond to my insurance carrier's request**. Your insurance policy is a contract between you and your insurance carrier and not between Starkville Orthopedic Clinic and your insurance carrier. _____ **Initials**

_____ _____

Patient Signature (Guardian if patient is a minor) Date

Starkville Orthopedic Clinic
HIPPA Privacy Notice Acknowledgement

I acknowledge that I have received and been given the opportunity to read the Starkville Orthopedic Clinic Privacy Notice dated September 23, 2013. I understand that a copy of the Notice will remain in my possession. If I have any questions concerning the Privacy Notice, I may contact the following person:

Mary A. Smith, DNP, FNP-BC
Administrator & Nurse Practitioner
Starkville Orthopedic Clinic
100 Wilburn Way
Starkville, MS
662-320-4008

_____ _____
Patient Printed Name Patient Date of Birth

_____ _____
Patient Signature or Legal Guardian Date Signed

My health related information may be released to the following people only:

Name	Relationship	Type of Information (circle)
_____	_____	All Medical Billing
_____	_____	All Medical Billing
_____	_____	All Medical Billing

STARKVILLE ORTHOPEDIC CLINIC PAYMENT POLICIES

Effective June 1, 2015

ALL PAYMENTS ARE DUE ON THE DATE OF SERVICE.

CO-PAYMENTS WILL BE PAID AT CHECK-IN

CO-PAYMENTS ARE DUE AT EACH VISIT UNLESS YOU ARE IN A GLOBAL PERIOD FOLLOWING SURGERY OR FRACTURE.

CO-INSURANCE PERCENTAGES ARE DUE AT THE TIME OF SERVICE, THIS APPLIES TO ALL INSURANCES. PATIENTS THAT DON'T HAVE A SUPPLEMENTAL INSURANCE WILL NEED TO BE PREPARED TO PAY THE PORTION NOT COVERED BY INSURANCE.

IF YOUR INSURANCE HAS A DEDUCTIBLE, **ALL** CHARGES APPLIED TO THE DEDUCTIBLE ARE DUE AND PAYABLE AT CHECK-OUT ON THE DAY OF SERVICE. IF YOU ARE UNSURE IF YOU HAVE AN OUTSTANDING DEDUCTIBLE, PLEASE LET US KNOW, WE WILL BE GLAD TO INFORM YOU OF YOUR BENEFITS, WE CHECK ALL PATIENT INSURANCES DAILY.

IF YOU ARE UNSURE WHY YOU ARE BEING CHARGED A COPAY, DEDUCTIBLE, OR PERCENTAGE, PLEASE CONTACT YOUR INSURANCE COMPANY. RATES ARE SET BY YOUR INSURANCE COMPANY, NOT STARKVILLE ORTHOPEDIC CLINIC.

PAYMENT PLANS ARE NOT OFFERRED UNLESS PRIOR ARRANGMENTS HAVE BEEN MADE WITH THE CLINICAL/BILLING MANAGER.

*****By signing this form, you acknowledge that you have read and agree to the Starkville Orthopedic Clinic Payment Policy*****

Signature: _____

Date: _____

Starkville ORTHOPEDIC CLINIC

PATIENT HEALTH HISTORY FORM

Patient Name: _____ **Height:** _____ **Weight:** _____

Race: ○ Caucasian ○ African American ○ Hispanic ○ Asian ○ Other _____

Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Other _____

Preferred Language: ○ English ○ Spanish ○ Chinese ○ Other _____

Preferred Pharmacy: _____

Referral Source: Doctor (name): _____ Other (ex. Google search): _____

Chief Complaint

Dominant Hand: ○ Right ○ Left ○ Ambidextrous

Description of Symptoms: (select only ONE primary symptom and ONE affected area)

○ Pain ○ Numbness/Tingling ○ Fracture ○ Stiffness Other: _____

Shoulder	○ Right	○ Left	Pelvis	○ Right	○ Left	Neck	○
Upper Arm	○ Right	○ Left	Hip	○ Right	○ Left	Upper Back	○
Elbow	○ Right	○ Left	Thigh	○ Right	○ Left	Mid Back	○
Forearm	○ Right	○ Left	Knee	○ Right	○ Left	Low Back	○
Wrist	○ Right	○ Left	Lower Leg	○ Right	○ Left	Buttocks	○
Hand	○ Right	○ Left	Ankle	○ Right	○ Left	Tail Bone	○
Thumb	○ Right	○ Left	Foot	○ Right	○ Left		
Index	○ Right	○ Left	Great Toe	○ Right	○ Left		
Middle	○ Right	○ Left	2nd Digit	○ Right	○ Left		
Third	○ Right	○ Left	3rd Digit	○ Right	○ Left		
Little	○ Right	○ Left	4th Digit	○ Right	○ Left		
			5th Digit	○ Right	○ Left		

Pain radiates from/to: (ex. from low back to right leg) _____

History of Present Illness

1. Is your problem the result of an injury or accident?

○ No Injury ○ Injury ○ Injury at Work ○ Auto Accident ○ Sport Injury ○ Prior Surgery

How long have the symptoms been present? (ex. 2 days, 4 months) _____

Describe the onset: ○ Acute (sudden) ○ Chronic condition (>3 months)

Onset Date: (mm/dd/yyyy) _____

2. Are you represented by an attorney? ○ Yes ○ No

Attorney Name: _____

Will there be any legal actions with respect to this problem? ○ Yes ○ No

3. Have you had a problem like this before? ○ Yes ○ No

Describe: _____

_____

4. Have you been seen in an ER? ○ Yes ○ No

Treating ER: (ex. St. Luke's Health) _____ **Date:** (mm/dd/yyyy) _____

 Patient Name: _____

History of Present Illness (continued)

5. Rate the pain (10 being the most pain):

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

6. Do the symptoms wake you from sleep?

○ Yes ○ No

7. Please describe the symptoms:

○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning ○ Shooting

8. What is the timing of the symptoms?

○ Constant ○ Intermittent (comes and goes)

9. Is the problem getting better or worse?

○ Getting better ○ Getting worse ○ Unchanged

10. What makes the symptoms worse?

○ Squatting ○ Kneeling ○ Sitting ○ Bending ○ Stairs ○ Twisting ○ Moving ○ Lying in bed
○ Running ○ Walking ○ Athletics ○ Standing ○ Gripping ○ Lifting ○ Reaching Overhead

11. Are there any other symptoms associated with this problem?

○ Redness ○ Bruising ○ Swelling ○ Numbness ○ Stiffness ○ Limping ○ Clicking ○ Locking
○ Popping ○ Tingling ○ Weakness ○ Giving way

Prior Testing / Treatment

Have you had any prior tests? ○ None ○ X-rays ○ MRI ○ CT Scan ○ Nerve Test (EMG/NCV) ○ Bone Scan

Have you had any prior treatment for this problem? ○ Yes ○ No

Type of treatment	Status of symptoms after treatment (select only those that apply)			Date of treatment
Ice	○ Improved	○ Worsened	○ Unchanged	
Heat	○ Improved	○ Worsened	○ Unchanged	
Rest	○ Improved	○ Worsened	○ Unchanged	
NSAIDs	○ Improved	○ Worsened	○ Unchanged	_____
Muscle Relaxers	○ Improved	○ Worsened	○ Unchanged	_____
Chiropractor	○ Improved	○ Worsened	○ Unchanged	_____
Physical Therapy	○ Improved	○ Worsened	○ Unchanged	_____
Home Exercise Program	○ Improved	○ Worsened	○ Unchanged	_____
Surgery	○ Improved	○ Worsened	○ Unchanged	_____
Injections	○ Improved	○ Worsened	○ Unchanged	_____
Bracing	○ Improved	○ Worsened	○ Unchanged	_____
TENS unit	○ Improved	○ Worsened	○ Unchanged	_____

Other/Comments: _____

_____

_____

 Patient Name: _____

Select all previous hospitalizations/surgeries: ○ None

○ Aneurysm (Brain) Surgery	○ Hysterectomy
○ Aortic Bypass / Vascular Surgery	○ LAP Band / Gastric Bypass Surgery
○ Appendectomy	○ Lumpectomy
○ Cataract (Eye) Surgery	○ Mastectomy
○ Cholecystectomy (Gallbladder)	○ Malignancy/Cancer
○ Heart Surgery	○ Stents
○ Hernia Repair	

Orthopedic on side:	Right	Left
Arthroscopy: Knee	○	○
Arthroscopy: Shoulder	○	○
Carpal Tunnel Release	○	○
Rotator Cuff Repair	○	○
Total Hip Replacement	○	○
Total Knee Replacement	○	○
Total Shoulder Replacement	○	○
Spinal Surgery - Indicate Level: _____		

Other Surgery

_____

_____

_____

Other Orthopedic Surgery

_____

_____

_____

Medical Questions

Mark all that currently apply:

○ Metal in body ○ Claustrophobic ○ Pregnant ○ Sleep Apnea ○ Uses a CPAP ○ Snores

Are you taking blood thinners? ○ Yes ○ No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months?

○ None for all

					None	Comments
1) GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool		○	_____
2) ENDO	○ Fever	○ Heat or Cold Intolerance	○ Night Sweats		○	_____
3) CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue		○	_____
4) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss		○	_____
5) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing		○	_____
6) CV	○ Chest Pain	○ Palpitations			○	_____
7) RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath		○	_____
8) GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems		○	_____
9) SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps	○ Psoriasis	○	_____
10) NEU	○ Frequent Falls	○ Loss of Coordination	○ Numbness		○	_____
	○ Change in Bowel	○ Change in Bladder	○ Dizziness			
11) PSY	○ Depression/Anxiety	○ Drug/Alcohol Addiction	○ Sleep Disorder		○	_____
12) HEM	○ Easy Bleeding	○ Easy Bruising	○ Anemia		○	_____

 Patient Name: _____

Family History

Have any direct relatives had any of the following disorders? ○ **None for all**

Father	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			
Mother	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			
Sibling	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			

Social History

Do you use tobacco? ○ Daily ○ Occasionally ○ Former smoker ○ Never ○ Unknown

Do you drink alcohol? ○ Daily ○ Occasionally ○ Rarely ○ Never

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Domestic Partnership

Are you currently working? ○ Yes ○ No ○ Retired ○ Disabled If no, what date did you last work? _____

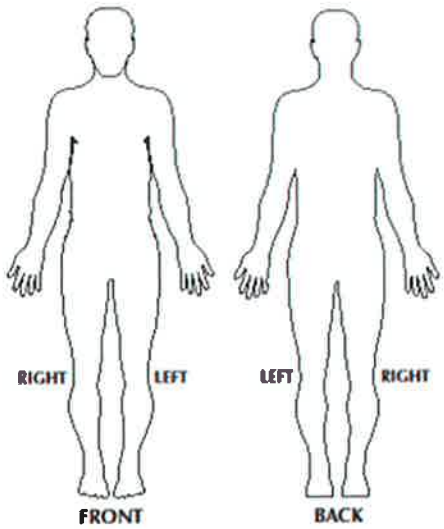
Please list work restrictions, if any: _____

Occupation: _____ **Employer:** _____ ○ **Student**

Pain Diagram

On the drawing below, mark an X where the pain is the worst.
Use the symbols below to show where you are having different kinds of pain:

Aching	^^^^
Numbness	====
Pins and Needles	oooo
Burning	xxxx
Stabbing Pain	////



 Patient Name: _____

Do you have any allergies? ○ Yes ○ No If Yes, please list below:

Medication, Relevant Food, or "Seasonal"	Reaction

Latex allergy? ○ Yes ○ No

Please list all medications you take on a regular basis: ○ None

Medication	Dosage and Frequency (e.g. 20 mg, once/day)

Do you have a personal history of any of the following? ○ None

○ Aneurysm Where: _____	○ Emphysema	○ Kidney Disease
○ Angina (Chest Pain)	○ Epilepsy	○ Kidney Stones
○ Arthritis Type: _____	○ Heart Attack	○ MRSA Infection
○ Asthma	○ Hepatitis Type: _____	○ Pacemaker
○ Bone or Joint Infections	○ HIV / AIDS	○ Phlebitis (Blood Clots)
○ Cancer Type: _____	○ High Cholesterol	○ Pulmonary Embolism
○ Chemotherapy / Radiation	○ Hypertension	○ Reaction to Anesthesia Type: _____
○ COPD	○ Hyperthyroidism	○ Seizures
○ Congestive Heart Failure	○ Hypothyroidism	○ Stomach Ulcers
○ Diabetes Type: _____ Last A1C: _____		○ Stroke / TIA
		○ Tuberculosis

Please list any other conditions or details of conditions marked above:

_____

Signature **Date**