TOA
TENNESSEE ORTHOPAEDIC ALLIANCE

Patient Name_____ Account Number_____

Patient Financial Responsibility

I acknowledge full financial responsibility for services rendered by Tennessee Orthopaedic Alliance. I understand that I am responsible for prompt payment of any amounts due including, but not limited to: co-pays, deductibles, and coinsurance amounts. I understand that payment of co-pays, deductibles and coinsurance amounts are expected at time of service, as well as any prior balances I may owe. I also consent that payment of authorized Medicare and any other insurance benefits may be made on my behalf directly to TOA for any medical and/or therapy, imaging, and/or surgical services furnished. I agree to be responsible for all reasonable attorney fees and collection costs in the event of default of payment of my charges, as outlined in office and financial policy guidelines.

Signed_____Date_____

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I authorize Tennessee Orthopaedic Alliance physicians and staff to render medical treatment and evaluation needed. I further authorize order of x-rays, injections, casting or other diagnostic tests and treatment that may be necessary to diagnose and treat my illness or injuries. I hereby give my consent to TOA to use or disclose, for the purpose of carrying out treatment, payment or healthcare operations, all protected health information contained in the patient record of:

_____.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice. I also understand that I will not be able to revoke this consent in cases where my provider has referred to it for purposes of disclosing my health information. Written revocation of consent must be sent to the physician's office, Attn: Administration.

Signed_____Date_____

Printed Name_____

Acknowledgment - Notice of Privacy Practices

I hereby acknowledge receipt of TOA's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential protected health information. I have reviewed TOA's Notice of Privacy Practices. I understand that TOA reserves the right to change its privacy practices that are described in that Notice. I also understand that any Revised Notice will be posted on TOAs website, available at each office, or mailed upon request.

Signed_____Date_____

Printed Name_____

If you are not the patient, please specify your relationship to the patient _____

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Office Use Only: MRN

Patient Information:	**Last:**	**First:**	**MI:**	**Preferred Name:**
	SS#:	**DOB:**	**Gender:** ○ **M** ○ **F**	**Previous Last Name:**
Billing Address:	(Do not use PO Box Number) **Street:**	**City:**	**State:**	**Zip:**
	Apartment #:	○ **Current** ○ **Home** ○ **Work** ○ **Mailing**		
	Home Phone: ( )	**Day Phone:** ( )		
	Cell Phone: ( )	**Email:**		
	Preferred Method of Contact: ○ **Home Phone** ○ **Day Phone** ○ **Cell Phone** ○ **Mailing Address** ○ **Email**			
	Are you currently living in a Nursing Facility: ○ **Yes** ○ **No**			
	Name of Nursing Facility:			
Race:	○ **Decline** ○ **Black or African American** ○ **Asian** ○ **American Indian or Alaskan Native** ○ **White** ○ **Other (please specify)**_____			
Language:	○ **English** ○ **Spanish** ○ **French** ○ **Arabic** ○ **Decline** ○ **Other (please specify)**_____			
Ethnicity:	○ **Hispanic or Latino** ○ **Not Hispanic or Latino** ○ **Unknown** ○ **Decline to Specify**			
Marital Status:	○ **Single** ○ **Married** ○ **Divorced** ○ **Separated** ○ **Widowed**			
Emergency Contact:	**Name:**	**Contact's Phone:** ( )		
	Relationship to Patient: ○ **Spouse/Partner** ○ **Child** ○ **Other Relative** ○ **Friend** ○ **Other**			
Responsible Party:	**Last:**	**First:**	**MI:**	
	SS#:	**DOB:**	**Gender:** ○ **M** ○ **F**	
	Cell Phone: ( )	○ **Parent** ○ **Spouse** ○ **Legal Guardian** ○ **Other**		
Primary Insurance:	**Insurance Company Name:**			
	Policy Holder's Name: **Last:**	**First:**	**MI:**	
	SS#:	**DOB:**	**Relation to Policy Holder:** ○ **Self** ○ **Spouse** ○ **Child** ○ **Other**	
	Subscriber ID:	**Group ID:**		
Secondary Insurance:	**Insurance Company Name:**			
	Policy Holder's Name: **Last:**	**First:**	**MI:**	
	SS#:	**DOB:**	**Relation to Policy Holder:** ○ **Self** ○ **Spouse** ○ **Child** ○ **Other**	
	Subscriber ID:			
Referring MD:	**Last Name:**	**First Name:**		
Primary Care Physician:	**Last Name:**	**First Name:**		
How did you hear about TOA?	○ **Referred by Physician or Other Provider** ○ **Friend or Family** ○ **Internet** ○ **Location** ○ **Returning Patient** ○ **Insurance Company** ○ **Phone Book** ○ **Billboard**			

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Patient Name:	**Age:**

What are we seeing you for today? ○ Right ○ Left ○ Bilateral (Both) Body Part: _____

What symptom(s) are you having? ○ Pain ○ Swelling ○ Weakness ○ Numbness ○ Tingling
○ Other (please specify)_____

Is this an injury? ○ Yes ○ No Is your problem work related? ○ Yes ○ No

When did your problem/injury begin? _____

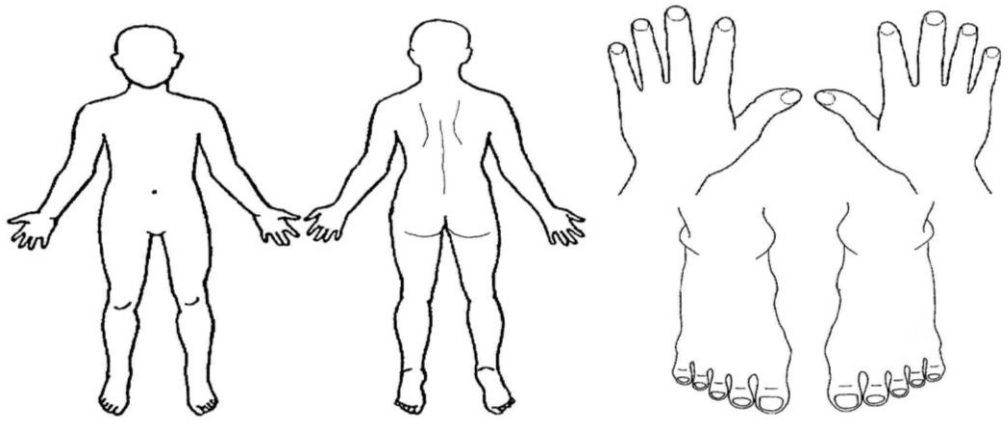
Where did the injury occur? ○ Home ○ School ○ During Sports (please list) _____
○ Work ○ MVA (In what state did this occur?) _____ ○ Other (specify) _____

Is an attorney involved? ○ Yes ○ No

How did the problem/injury occur? _____
_____

Using the symbols below, mark on the body, hands, or feet where you feel the following:

Numbness ===== Pins and Needles 00000 Burning xxxxx Stabbing ///// Aching +++++



Which are you?
○ Right Handed
○ Left Handed
○ Ambidextrous

How severe is your pain? None 0 1 2 3 4 5 6 7 8 9 10 Severe

What makes your symptoms worse? ○ Daily activity ○ Exercise ○ Walking ○ Standing ○ Stairs
○ Repetitive activities ○ Driving ○ Other (specify) _____

What makes your symptoms better? ○ Nothing ○ Heat ○ Ice ○ Rest ○ Splinting
○ Medication ○ Other (specify) _____

Have you received any treatment? ○ Yes ○ No If yes, by whom?

Please indicate all treatment received prior to today's visit ○ X-ray ○ MRI ○ EMG ○ Myelogram/CT ○ Surgery
○ Physical Therapy ○ Injection ○ Medication ○ Pain Management

Provider's Notes (office use only):
_____
_____
_____

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Patient Name: | Office Use Only: MRN

Vitals

Height: _____

Weight: _____

Have you had a flu shot this season? ○ Yes ○ No

If yes, what month and year?

If you are 65 years or older, have you ever had a pneumonia vaccine? ○ Yes ○ No

If yes, what year?

If you are 65 years or older, have you fallen in the last year? ○ Yes ○ No

If yes, number of falls _____ Did an injury occur? ○ Yes ○ No

Review of Systems

○ I have NO other symptoms or complaints.

(please check all that apply)

Constitutional:	○ Chills	○ Fatigue	○ Fever	○ Night Sweats	○ Weakness
HEENT:	○ Blurred Vision	○ Headache	○ Hearing Loss	○ Ringing in Ears	○ Vertigo
Respiratory:	○ Cough	○ Recent Infection		○ Known TB Exposure	
Cardiovascular	○ Chest Pain	○ Heart Murmur	○ Leg Swelling	○ Syncope/Fainting	○ Irregular Heartbeat
GI:	○ Abdominal Pain	○ Constipation	○ Black Tarry Stools	○ Diarrhea	○ Nausea ○ Vomiting
Genitourinary:	○ Blood in Urine	○ Incontinence	○ Painful Urination	○ Frequent Urination	
Endocrine:	○ Cold Intolerance	○ Heat Intolerance			
Neurological:	○ Difficulty Walking	○ Dizziness	○ Poor Coordination	○ Memory Loss	○ Muscle Weakness
Emotional:	○ Depression	○ Insomnia			
Hematologic:	○ Bleeding Tendency	○ Bruising Tendency			

Medical History:

○ I have NO medical history.

* Special Orthopaedic Alerts

Please check all that apply

○ *AIDS/HIV	○ Congestive Heart Failure	○ Fibromyalgia	○ MI/Heart Attack	○ *Previous MRSA
○ Alzheimer's	○ COPD/Emphysema	○ *Hepatitis	○ Obesity	○ Psoriasis
○ Anemia	○ Coronary Artery Disease	○ High Blood Pressure	○ Osteoporosis	○ Scoliosis
○ Arthritis	○ Depression	○ Inflammatory Bowel	○ Parkinson's	○ Seizures
○ Asthma	○ *Diabetes	○ *Kidney Disease	○ Pulmonary Embolism	○ *Sleep Apnea
○ *Blood Clot	○ Excessive Bleeding	○ *Liver Disease	○ *Peptic Ulcers	○ Stroke
○ Cancer, Type: _____		○ Lyme Disease	○ *Pregnant (currently)	○ Thyroid Disease

○ Other: _____

Surgical History:

○ I have NO surgical history.

Have you ever had any problems with anesthesia? ○ Yes ○ No

Do you have a(n) ○ *Pacemaker ○ Implanted nerve or bladder stimulator ○ Defibrillator

Please list all surgeries

Name of Surgery:	Side:	Name of Surgery:	Side:
_____	○ R ○ L ○ Both	_____	○ R ○ L ○ Both
_____	○ R ○ L ○ Both	_____	○ R ○ L ○ Both
_____	○ R ○ L ○ Both	_____	○ R ○ L ○ Both
_____	○ R ○ L ○ Both	_____	○ R ○ L ○ Both

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Patient Name:										Office Use Only: MRN
Family History	○ I have NO family history.									M = Mother F = Father B = Brother S = Sister
	Arthritis	○ M ○ F ○ B ○ S	Liver Disease	○ M ○ F ○ B ○ S	Other: _____	○ M ○ F ○ B ○ S				
	Blood Disorder	○ M ○ F ○ B ○ S	Mental Illness	○ M ○ F ○ B ○ S	_____	○ M ○ F ○ B ○ S				
	Cancer	○ M ○ F ○ B ○ S	Muscle Disease	○ M ○ F ○ B ○ S	_____	○ M ○ F ○ B ○ S				
	Heart Disease	○ M ○ F ○ B ○ S	Peripheral Vascular	○ M ○ F ○ B ○ S	_____	○ M ○ F ○ B ○ S				
	Diabetes	○ M ○ F ○ B ○ S	Kidney Disease	○ M ○ F ○ B ○ S	_____	○ M ○ F ○ B ○ S				
	Genetic Disease	○ M ○ F ○ B ○ S	Stroke	○ M ○ F ○ B ○ S	_____	○ M ○ F ○ B ○ S				
	Hypertension	○ M ○ F ○ B ○ S	Thyroid Disorder	○ M ○ F ○ B ○ S	_____	○ M ○ F ○ B ○ S				
Social History	Have you ever used tobacco?	○ Never	○ Former	○ Decline to Answer	○ Current Every Day	○ Current Some Days	Type: _____			
	Alcohol Use:	○ None	○ Rarely	○ Socially	○ Daily	○ Alcoholism				
	Recreational drug use:	○ None	○ Rarely	○ Socially	○ Daily	○ Drug Addiction				
	Employment/Student Status:	○ Student	○ Employed	○ Retired	○ Unemployed					
	Employer/Occupation:				School:					
Pharmacy Information	Name of Pharmacy:				Phone #: ( )					
	Address or Street Name:				City:					
Current Medication List	○ I do NOT take any medications.									
Please list all prescriptions, over-the-counter medications, supplements, and vitamins, or provide a list to the front desk staff.	Medication Name:			Dosage:			Times per Day:			
Allergies	○ I have NO medication/food allergies.									
	List all medication/food allergies:						Reaction:			

Physician Signature: _____ Date: _____

Patient Name: _____

DOB: ____/____/____ **Acct#:** _____

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Patient's Preferences

Regarding their PHI

Telephone Communication Preferences

Location	May we call you here?		May we leave a message?	
Home	❑ Yes	❑ No	❑ Yes	❑ No
Work	❑ Yes	❑ No	❑ Yes	❑ No
Mobile Phone	❑ Yes	❑ No	❑ Yes	❑ No
Other _____	❑ Yes	❑ No	❑ Yes	❑ No

Mail Communication Preferences

May we send mail to your home address? ***(If no, please provide an alternate mailing address below.)*** ❑ Yes ❑ No

_____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply.)

	Name	Telephone
❑ Spouse	_____	_____
❑ Caretaker	_____	_____
❑ Child	_____	_____
❑ Parent	_____	_____
❑ Other	_____	_____

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

❑ Yes
❑ No

Patient or Personal Representative Signature _____ Date _____