ORTHOPEDIC URGENT CARE

PATIENT INFORMATION

PATIENT NAME Last First M.I.		Social Security Number	
ADDRESS Street		DATE OF BIRTH	SEX Female Male
City State Zip	Home Phone	Cell Phone	Work Phone
EMAIL		Marital Status ☐ Single ☐ Widowed ☐ Divorced ☐ Married	

PREFERRED METHOD OF CONTACT ☐ Home Phone ☐ Cell Phone ☐ Work Phone

RACE ☐ African American ☐ Asian ☐ Hispanic ☐ Caucasian ☐ Native American ☐ Other

ETHNICITY ☐ Hispanic ☐ Non-Hispanic

EMPLOYER	EMPLOYER PHONE NO.
PHARMACY NAME & LOCATION	PATIENTS OCCUPATION

HOW DID YOU HEAR ABOUT US ☐ Community Event ☐ Friend/Family ☐ Employer ☐ High School/Sport ☐ Hospital ☐ Insurance ☐ Magazine or Newspaper ☐ Physician ☐ Radio or Television ☐ Website or Online

PERSON RESPONSIBLE FOR CHARGES

NAME	SOCIAL SECURITY NUMBER
ADDRESS Street	DATE OF BIRTH
City State Zip	CONTACT PHONE NO.

If this is a job-related injury? Yes ☐ No ☐ Employer, if different than above _____

If due to an injury, date of loss: _____/_____/_____

Will an attorney or Liability Carrier be involved in payment of charges? ☐ Yes ☐ No If yes, please explain: _____

Is injury related to: ☐ Accident ☐ Job Related ☐ Other: _____

If job related: Claim # _____ Case Manager: _____ Phone No. _____

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN	NAME OF REFERRING PHYSICIAN

EMERGENCY INFORMATION

IN CASE OF EMERGENCY NOTIFY NAME	RELATIONSHIP	PHONE NO.
ADDRESS Street	City State	Zip

INSURANCE INFORMATION

PRIMARY	SECONDARY
Insured Name: _____	Insured Name: _____
Insured DOB: _____	Insured DOB: _____
Insurance Name: _____	Insurance Name: _____
Policy ID #: _____	Policy ID #: _____
Group/Account #: _____	Group/Account #: _____
Social Security #: _____	Social Security #: _____
Relation to Patient:	Relation to Patient:

I hereby certify the above information is true and correct to the best of my knowledge. I understand that while Orthopedic Urgent Care contracts with many insurance companies, it is my responsibility to verify with my plan that Orthopedic Urgent Care is a participating provider. It is also my responsibility to find out what my coverage options are with my insurance plan. I hereby authorize Orthopaedic Urgent Care to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of my insurance coverage. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPPA guideline.

Patient Signature: _____ Date: _____

Revised: 2/2018

Orthopedic Urgent Care
Privacy and Financial Policy

Your treatment, payment, enrollment or services for benefits at Orthopedic Urgent Care is not dependent upon whether you sign this Privacy and Disclosure statement. You have the right to revoke this Privacy and Disclosure Statement at any time by sending a written notice of revocation Orthopedic Urgent Care at 108 Rue Louis XIV Lafayette, LA 70508, Attn: Privacy Officer. Our Practice Manager and front office staff will be glad to discuss these acknowledgements and authorizations with you.

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Orthopedic Urgent Care, which explains its legal duties and privacy practices with respect to my protected health information

I hereby agree that Orthopedic Urgent Care may disclose all of my protected health information to the following individuals, all of whom are involved in my care for any purpose related to my treatment or the payment of my care.

Name: _____Relationship: _____

Name: _____Relationship: _____

Orthopedic Urgent Care places its patients' needs first; however, we must be financially responsible to continue to serve.

- I understand that it is my responsibility to know my insurance benefits and plan coverage. My insurance may or may not cover the services provided at Orthopedic Urgent Care. To obtain the most accurate information, please check with your insurance carrier to discuss the benefits provided by your medical plan prior to your visit to fully understand your anticipated out of pocket costs.
- I understand that co-payments, deductibles, co-insurance and non-covered services are to be paid at or before the time of service. Orthopedic Urgent Care accepts cash, checks, major credit cards, and debit cards.
- I understand that I may be contacted by the telephone regarding my outstanding balance with Orthopedic Urgent Care.
- I understand that if I do not have my insurance and, referral, and/or co-payment, that my appointment may be rescheduled until such time that I can provide the required documents or payments.
- I understand if my account has a patient responsibility amount that is not paid in full within 90 days then my account may be placed with an outside collection agency. No additional appointments will be made for delinquent accounts until they are brought current unless the appointment is of an urgent nature.
- I understand that a $35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. Non-Sufficient Fund checks must be redeemed with certified funds (credit card or cash).
- I understand that there may be fees associated with medical records requests and completion of forms by a physician. I understand that I may be responsible for these fees.

Statement of Financial Responsibility: I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my insurance plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO), or any other payer. I have read, and I understand the above Financial Policy and I agree to abide by its terms.

Patient or Guarantor Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

Revised: 2/2018

Patient Name: _____ Patient DOB: _____

ALLERGIES

Please list all allergies below: ☐None

MEDICATIONS

Please list all medications you are currently taking below: ☐None

PAST SURGICAL HISTORY

Please list all past surgeries or hospitalizations

PATIENT PAST MEDICAL HISTORY

☐ Anemia	☐ Gout	☐ Peripheral Vascular Disease
☐ Anxiety	☐ Heart Attack	☐ Pregnant
☐ Asthma	☐ Heart Disease	☐ Psychological Disorder
☐ Bladder Infections	☐ Hepatitis	☐ Rheumatoid Arthritis
☐ Blood Clots	☐ High Cholesterol	☐ Seizures
☐ Blood Disorders	☐ High Blood Pressure	☐ Shortness of breath
☐ Cancer	☐ Kidney Disease	☐ History of MRSA (staph infection)
Type: _____	☐ Liver Disease	☐ Sleep Apnea
☐ Chest Pain	☐ Migraines	☐ Stroke
☐ COPD	☐ Neurological Disorder	☐ Stomach Ulcers
☐ Coronary Arterial Bypass	☐ Neuropathy	☐ Thyroid Disease
☐ Depression	☐ Osteoarthritis	☐ TB
☐ Diabetes	☐ Osteoporosis	☐ HIV
☐ Fibromyalgia	☐ Pacemaker	☐ Other: _____

FAMILY HISTORY

Check one is someone in your family has/has any of the following

	Mother	Father	Sibling(s)	Grandparent(s)
Diabetes	☐	☐	☐	☐
Hemophilia	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Malignant Hyperthermia	☐	☐	☐	☐
Anesthetic Reaction	☐	☐	☐	☐

Patient Name: _____ Patient DOB: _____

SOCIAL HISTORY

☐ L Handed
Occupation: _____When was the last time you worked? _____ ☐ R Handed

☐Restricted or light duty ☐ Temporary ☐ Permanent disability ☐Retired ☐Unemployed/Seeking Job

Are you currently under worker's compensation? ☐Yes ☐No
Is there an ongoing lawsuit related to today's visit? ☐Yes ☐No
Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Tobacco: ☐No ☐Yes How many packs per day? _____ How many years? _____ ☐Quit _____yrs ago
Alcohol: ☐No ☐Yes How much do you drink daily? _____☐Quit _____ yrs ago
Have you ever drank heavily or abused alcohol? ☐No ☐Yes
Drugs: Have you ever used any illicit substances? ☐No ☐Yes Type: _____
Have you ever been addicted to or misused prescription drugs? ☐No ☐Yes

REVIEW OF SYSTEMS

Are you currently experiencing any of the following? ☐check here if unknown

	Yes	No		Yes	No		Yes	No
GENERAL			**CARDIOVASCULAR**			**GASTROINTESTINAL**		
Loss of appetite	☐	☐	Chest pain	☐	☐	Nausea or vomiting	☐	☐
Recent weight loss	☐	☐	Palpitations	☐	☐	Blood in stool	☐	☐
Fever or chills	☐	☐	**EYES**			Heartburn	☐	☐
RESPITORY			Blurred vision	☐	☐	Constipation	☐	☐
Shortness of breath	☐	☐	Double vision	☐	☐	**NEUROLOGICAL**		
Chronic Cough	☐	☐	Loss of vision	☐	☐	Headaches	☐	☐
KIDNEY/BLADDER/URINE			**SKIN**			Seizures	☐	☐
Painful Urination	☐	☐	Frequent rashes	☐	☐	Dizziness	☐	☐
Blood in urine	☐	☐	Skin ulcers	☐	☐			
Kidney problems	☐	☐	Lumps	☐	☐			
HEMATOLOGICAL/LYMPHATIC			**ENDOCRINE**					
Easy bruising	☐	☐	Thyroid disease	☐	☐			
Easy bleeding	☐	☐	Heat/Cold intolerance	☐	☐			
PSYCHIATRIC			**HEAD/EARS/NOSE/THROAT**					
Depression	☐	☐	Hoarseness	☐	☐			
Drug/Alcohol addiction	☐	☐	Trouble swallowing	☐	☐			
Suicidal Thoughts	☐	☐	Hearing loss	☐	☐			

PRESENT MEDICAL INFORMATION

Height: _____ Weight: _____

Type of pain: (please circle one) Unsure Sharp Dull Burning Cramping Frank Throbbing Stabbing Traveling Achy Other:_____

What body part is involved? (please check all that apply)

	R	L		R	L		R	L		R	L
Ankle:	☐	☐	Arm:	☐	☐	Back:	☐	☐	Elbow:	☐	☐
Finger: _____	☐	☐	Foot:	☐	☐	Hand:	☐	☐	Hip:	☐	☐
Knee:	☐	☐	Leg:	☐	☐	Neck:	☐	☐	Pelvis:	☐	☐
Shoulder:	☐	☐	Toe:	☐	☐	Wrist:	☐	☐	Other: _____		

How long ago did this problem start? _____ ☐Days ☐Weeks ☐Months ☐Years

Were you seen in the ER for this problem? ☐ Yes ☐No If yes, which ER? _____

On a scale of 0-10 (10 being the worst) how severe is your pain?

What is the quality of your pain: ☐1☐2☐3☐4☐5☐6☐7☐8☐9☐10

Do you have any of the following? ☐Bruising ☐Joint Instability ☐Hands Feel Clumsy ☐Locking/Catching ☐Weakness
☐Numbness ☐Poor Balance ☐Loss of Control of Bladder ☐Tingling ☐Swelling