TENNESSEE ORTHOPAEDIC CLINICS

PATIENT INFORMATION

Today's date:		Doctor You Are Seeing:		
Have you been to our offices before? If yes, when? By Whom?				
Patient's Full Name:				
Street address:		City/State/Zip:		
Home phone:	Email:	Social Security #:	Sex: ❑ M ❑ F	Date of Birth:
Marital Status: Single / Mar / Div / Sep / Wid				
Employer		Work #:		Occupation:
Employer's Address:		Is Patient a Student?		Where:
Spouse's Name:		Spouse's Employer:		Work #:
Emergency Contact Person (or next of kin not living with you):		Address:		Phone #:
INFORMATION ABOUT ILLNESS OR INJURY				
Was injury caused by accident? Yes / No Date:	Injury Occurred: ❑ Due to Auto Accident? ❑ On the job ❑ Other		State where auto accident occurred:	Date of First Symptom:
Patient Seen in Emergency Room? Yes/ No Date:	Which Hospital?	How did You Hear About Our Office? ❑ Family/Friend ❑ Yellow Pages ❑ Insurance Co. ❑ Radio ❑ Attorney ❑ Employer ❑ Newspaper ❑ Other		
Body Part to be Examined/Complaint:				
Name of Referring Physician:		Address:		
Name of Primary Care Physician:				

GUARANTOR NAME (RESPONSIBLE FOR PAYMENT) **Check one:** ❑ Self ❑Spouse ❑ Mother ❑ Father ❑ Employer ❑ Other

Full Name:	Home Phone:	Date of Birth:	Social Security #
Address:			
Employer:	Work Phone:	Occupation:	
Employer's Address:			

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

Primary Insurance			**Secondary Insurance**		
Insurance Company Name:			Insurance Company Name:		
Group #	ID#		Group #	ID#	
Name of Insured	Date of Birth		Name of Insured	Date of Birth	
Policy Holder Address			Policy Holder Address		
Phone:	Social Security:	Sex:	Phone:	Social Security:	Sex:
Policy Holder Employer:			Policy Holder Employer:		
Patient's Relationship To Insured:			Patient's Relationship To Insured:		
Referral Information			**Method of Payment**		
Does your insurance require a referral from a primary care physician? Yes / No If yes, has the referral been obtained? Yes / No			❑ Cash ❑ Check ❑ Credit Card		

Updated_____ _____ Updated_____ _____ Updated_____ _____

Emp Int Emp Int Emp Int

TENNESSEE ORTHOPAEDIC CLINICS

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of any medical information necessary for the processing of insurance claims. I hereby assign all medical benefits to include major medical benefits to which I am entitled to Tennessee Orthopaedic Clinics, P.C. this will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. I further agree to be solely responsible for any balances that my insurance does not pay.

Signature: Date:

REFERRAL INFORMATION:
I understand that if a referral is required by my primary physician, I am responsible for obtaining this referral and following the rules/regulations of my insurance provider. I understand that failure to obtain my referral could result in my responsibility for payment of services rendered.

Signature: Date:

In the event this account is turned over for collection, patient (or responsible party) agrees to pay for all costs of collections, including court costs and attorney's fees.

Signature: Date:

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages and other forms of communications.

Signature: Date:

TENNESSEE ORTHOPAEDIC CLINICS

TOC SPINE
ORTHOPAEDIC CENTER FOR SPINAL EXCELLENCE

I, _____, give TOC permission to disclose my health information and account information to: Please list all parties we may discuss this information with (spouse, other family members, etc), including yourself if the patient is a minor. ***Please give full names.***

_____

_____

_____

_____

_____

_____

Where and how may we contact you?

	Yes	**No**	
Home	☐	☐	If yes, please give phone number _____
Work	☐	☐	If yes, please give phone number _____
Email	☐	☐	If yes, please give us your email address _____
Other/Cell	☐	☐	If yes, please give us another contact number _____

May we leave a message on your answering machine or voicemail?

At Home? Yes ☐ ☐ At Work? Yes ☐ No ☐

May we leave a message if there is no answering machine?

At Home? Yes ☐ ☐ At Work? Yes ☐ No ☐

Signature of patient or responsible party Date

TENNESSEE ORTHOPAEDIC CLINICS

PROOF NOTICE OF PRIVACY POLICIES RECEIVED

Your Rights Regarding Your Protected Health Information

We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our legal duties and privacy practices with respect o protected health information. We are required to abide by the terms of the Notice currently in effect. We reserve the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. If we change the Notice, we will provide a copy to the revise notice through in-person contact.

Your Rights Regarding Your Protected Health Information

You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated.

If you wish to complain to us, please do so in writing, and direct your complaint to the Privacy Officer.

You will not be penalized for filing a complaint

Contact Information

PLEASE CONTACT THE PRIVACY OFFICER AT THE SITE YOUR SERVICE WERE GIVEN

Effective Date

This Notice is effective April 14, 2003

Please print name Account#

Signature of patient or responsible party Date

TENNESSEE ORTHOPAEDIC CLINICS

Medical History

City of Residence: _____

Occupation: _____

Patient Name:_____ Account # _____

Height:_____ Weight:_____ Age:_____ Gender: ☐ M ☐ F (R L Handed)

Referred By: _____ Primary Care Dr.: _____

Present complaint: Painful Area(s)_____

Motor vehicle accident? ☐ Yes ☐ No Work Related? ☐ Yes ☐ No Date of Injury_____

If due to an injury or accident, give details of event_____

_____

_____

Have you ever had problems with this area before? ☐ Yes ☐ No If yes, explain_____

_____

Are you currently seeing a physician, therapist, chiropractor, podiatrist, etc. for this problem?

☐ Yes ☐ No If yes, please list:_____

Allergies: _____

_____

Latex Allergy? ☐ Yes ☐ No Pain Management Clinic? ☐ Yes ☐ No

CURRENT MEDICATIONS (ex: Digoxin 0.25 mg 1x/Daily)

Drug	Dose	Frequency	Drug	Dose	Frequency

Office Note:

Signature_____ Date_____ Updated_____ Initials_____ Updated_____ Initials_____

Name: _____ Date: _____

Medical Problem List *Mark all applicable boxes*

- ☐ Anemia
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clot/D.V.T.
- ☐ Cancer
  - ☐ Breast
  - ☐ Lung
  - ☐ Skin
  - ☐ Prostate
  - ☐ Renal
  - ☐ Myeloma
  - ☐ Other
- ☐ Cardiac Pacemaker/ Defibrillator
- ☐ Cardiomyopathy
- ☐ Cirrhosis
- ☐ Congestive Heart
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Emphysema/COPD
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Heart Attack
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Failure High Blood Pressure
- ☐ High Thyroid
- ☐ Low Thyroid
- ☐ Lymphedema
- ☐ Kidney Transplant
- ☐ Lupus
- ☐ Mini-strokes
- ☐ Multiple Sclerosis
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Panic Attack
- ☐ Parkinson's
- ☐ Psoriasis
- ☐ Pulmonary Embolus
- ☐ Renal Failure
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stoke
- ☐ Tuberculosis
- ☐ Ulcer Disease

Please list other problems:

_____

_____

List All Surgeries (ex: Appendectomy – 1963)

_____

_____

_____

_____

List All Surgeries (ex: Appendectomy – 1963)

_____

_____

_____

_____

FAMILY HISTORY: Do your immediate relatives have any of the following conditions? If so, please mark all applicable boxes.

- ☐ Cancer
- ☐ Arthritis
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Bleeding Problems
- ☐ Hemophilia
- ☐ Anesthetic Complication
- ☐ Pulmonary Embolus (PE)
- ☐ Sickle Cell Anemia
- ☐ Any Other Disease_____

SOCIAL HISTORY: Place mark in appropriate box for each question

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Alcohol Consumption per Week? ☐ None ☐ 1-3 ☐ 3-4 ☐ more than 6

Do you smoke? ☐ No ☐ Yes ☐ If yes, how many packs per day?_____ How long?_____

Are you on disability? ☐ No ☐ Yes

REVIEW OF SYSTEMS:

Constitutional
- ☐ Unexplained weight loss
- ☐ Fever/chills
- ☐ Night sweats

Cardiovascular
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Poor circulation
- ☐ Exercise problems

Genitourinary
- ☐ Can't control bladder
- ☐ Can't urinate
- ☐ Blood in urine

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea/vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool

Respiratory
- ☐ Shortness of breath
- ☐ Coughing

Endocrine
- ☐ Too hot, too cold
- ☐ Can't take stress
- ☐ Gland problems

Skin/Breast
- ☐ Rash
- ☐ Hair loss
- ☐ Bruising
- ☐ Breast lump

Eyes
- ☐ Blurry vision
- ☐ Wear glasses
- ☐ Blind/color blind

Neurological
- ☐ Headaches
- ☐ Weakness
- ☐ Numbness
- ☐ Dizziness

Psychiatric
- ☐ Depression
- ☐ Anxiety

Hematological/Lymphatic
- ☐ Easy bruising or bleeding
- ☐ Lumps in neck, armpit or groin
- ☐ Anemia

Ears, Nose, Throat, Mouth
- ☐ Hearing problems/deaf
- ☐ Cant' taste/can't smell
- ☐ Swallowing problems
- ☐ Sore throat

Musculoskeletal
- ☐ Muscle, bone joint swelling
- ☐ Broken bones
- ☐ Pain in arm, leg, neck, back

Allergy/Immunologic
- ☐ Frequent colds, infections, allergies
- ☐ Hives

HOBBIES/INTERESTS: _____

Signature_____ Date_____ Updated_____ Initials_____ Updated_____ Initials_____