OrthoNOW because injuries don't happen by appointment
ORTHOPEDIC URGENT CARE

How did you hear about our practice? _____

Would you like to receive text messages from OrthoNOW? ❑ **YES** ❑ **NO**

First Name: _____ **M.I.:**_____ **Last Name:** _____

Address: _____
Street **City** **State** **Zip Code**

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Date of Birth: _____**Social Security:** _____ **Sex:** _____**Male** _____ **Female**

Email Address: _____

Marital Status: ___Single ___Married ___Divorced ___Widowed **Employment Status:** ___Employed ___Unemployed ___Retired

Ethnicity: _____ **Primary language:** _____ **Race:** _____

Employer: _____Employer Address: _____

Type of injury you are being treated for: ____work related ____auto accident ____sports injury ____other: _____

Primary **Insurance** ***Company Name:*** _____Phone: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Social Security Number: _____ Relationship to patient: _____

Secondary **Insurance** ***Company Name:*** _____Phone: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ Date of Birth: _____

Social Security Number: _____ Relationship to patient: _____

Workers Comp / Auto Insurance Company **Name:** _____

Address for Claims: _____
Street **City** **State** **Zip Code**

Adjuster Name: _____Phone/ Fax Number: _____

Emergency Contact (not in the same household): _____ Relationship_____

Phone: _____ Address: _____

Primary Care Physician / Pediatrician

Name: _____ Phone: _____

I do hereby consent to any medical care which is deemed advisable or necessary by my physician and grant authority to OrthoNOW, to administer and perform all examinations, treatments, diagnostic procedures and surgeries needed now or in the future. I guarantee payment for all services rendered. All medical benefits including major medical benefits, private insurance and any other health plan, are assigned to OrthoNOW. The signature below confirms all of the information provided herein is true and accurate. Photocopy of this consent is to be considered as valid as the original.

Signature: _____ **Date:** _____

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Medical History

Name: _____ Date: _____ Age: _____

Height: _____ Weight: _____ Dominant Hand: ☐ Right ☐ Left Date of Injury: _____

Reason for visit: _____

Accident Related Injury: ___ Yes ___ No Type of accident: ___ Work ___ Home ____ Sports ____ Other

Is a third party responsible? If yes who, _____ Do you have an attorney: If so, who: _____

Occupation: _____ Have you seen a physician in the last 6 months? _____ yes _____ no

If yes, Name of physician and what condition you were treated for: _____

Allergies: (food / drugs / others) _____

Medications: **(Please provide list of current medications taken)** _____

Surgical History: **(indicate type of surgery and date)** _____

Do you exercise? _____ If yes, how often: _____

Medical History:	**YOU**		**FAMILY MEMBER**		
	YES	**NO**	**YES**	**NO**	**If yes, Describe:**
Arthritis	____	____	____	____	_____
Asthma	____	____	____	____	_____
Blood Pressure	____	____	____	____	_____
Cancer	____	____	____	____	_____
Circulation	____	____	____	____	_____
Diabetes	____	____	____	____	_____
Heart Disease	____	____	____	____	_____
High Blood Pressure	____	____	____	____	_____
Liver	____	____	____	____	_____
Lungs	____	____	____	____	_____
Migraine	____	____	____	____	_____
Stroke	____	____	____	____	_____
Thyroid	____	____	____	____	_____
Tuberculosis	____	____	____	____	_____
Do you smoke?	____	____	____	____	Frequency_____
Substance abuse	____	____	____	____	_____
Use Illicit Drugs	____	____	____	____	_____
Consume Alcohol	____	____	____	____	Frequency_____
Are you HIV positive?	____	____	____	____	_____

Other: _____
_____

Are you currently or could you be pregnant? _____ Last menstrual period (If applicable):_____
How many times have you been pregnant? (If applicable):_____ Number of Children: _____

I certify that the above information is correct

Patient Signature: _____Date: _____

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Review of Systems

Constitutionals:

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Headache	☐ Yes	☐ No

Other: _____

Integumentary:

Skin Rash	☐ Yes	☐ No
Boils	☐ Yes	☐ No
Persistent Itching	☐ Yes	☐ No

Other: _____

Eyes:

Blurred Vision	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Pain	☐ Yes	☐ No

Other: _____

Muscular Skeletal:

Joint Pain	☐ Yes	☐ No
Neck Pain	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No

Other: _____

Neurological:

Dizziness	☐ Yes	☐ No
Numbness/Tingling	☐ Yes	☐ No
Tremors	☐ Yes	☐ No

Other: _____

Ear/Nose/Throat/Mouth:

Ear Infection	☐ Yes	☐ No
Sore Throat	☐ Yes	☐ No
Sinusitis	☐ Yes	☐ No

Other: _____

Endocrine:

Excessive Thirst	☐ Yes	☐ No
Too Hot/Too Cold	☐ Yes	☐ No
Tired	☐ Yes	☐ No

Other: _____

Genitourinary:

Urine Retention	☐ Yes	☐ No
Painful Urination	☐ Yes	☐ No
Urine Frequency	☐ Yes	☐ No

Other: _____

Gastrointestinal:

Abdominal Pain	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Indigestion/Heartburn	☐ Yes	☐ No

Other:_____

Respiratory:

Wheezing	☐ Yes	☐ No
Frequent Cough	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No

Other:_____

Cardiovascular:

Chest Pain	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No

Other: _____

Hematologic:

Swollen Glands	☐ Yes	☐ No
Blood Clotting	☐ Yes	☐ No

Other: _____

Psychological:

Are you happy with your life?	☐ Yes	☐ No
Do you feel severely depressed?	☐ Yes	☐ No
Have you considered suicide	☐ Yes	☐ No

Patient Signature: _____ Date: _____

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Acknowledgement of Privacy Practices

I hereby acknowledge that I have received a copy of OrthoNOW Notice of Privacy Practices as required by federal law.

Patient Signature: _____ Date: _____

Reason Patient / Personal Representative failed to sign:

_____

_____
Staff Signature

Financial Responsibility & Financial Policy:

I hereby acknowledge that I have received a copy of OrthoNOW Financial Policy and have read the Financial Responsibility Statement. By signing below, you agree to all of the terms and conditions contained herein the OrthoNOW Financial Policy and the Financial Responsibility Statement will be in full force and effect.

Patient Signature: _____ Date: _____

Patient Consent for use and disclosure of Protected Health Information

Patient Signature: _____ Date: _____

I authorize the office of OrthoNOW to disclose protected health information to the following:

Name and relationship of person(s) authorized to receive information:

_____ _____

_____ _____

Please circle one:

I (please circle one) **DO** **DO NOT** authorize the office of OrthoNOW to leave telephone messages regarding my protected health information on the voicemail or answering machine.

Patient Signature: _____ Date: _____

Female Patients- Radiologic Consent

We will be performing a radiological examination using digital x-rays. The radiation used may be harmful to an unborn child/developing fetus, especially during the first trimester. In order to help prevent the accidental irradiation of an unrecognized pregnancy and in accordance with the National Standards, we require the following information of female patients of child bearing age.

Your Date of Birth: _____ Birth Control Measures: _____ _____

Date of your last menstrual cycle: _____ Is there any possibility that you may be pregnant? YES ____ NO ____

I have been fully informed of the risk involved in radiation of a first trimester pregnancy and assume the responsibility for any consequences from the procedures that I am about to have. I understand that I will not hold OrthoNOW, LLC and Badia Hand to Shoulder, LLC responsible for any potential harm to myself or my unborn child. By signing below I consent to the necessary X-ray procedures.

Patient Signature: _____Date: _____ Witness: _____