

heekin orthopedic SPECIALISTS

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DATE: _____ MARITAL STATUS: M W S D AGE: _____

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ SSN: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

May we contact you by e-mail? YES NO e-mail address _____

EMPLOYER: _____ OCCUPATION: _____

ARE YOU A VETERAN? YES NO

DRIVER'S LICENSE #: _____

SPOUSE: _____ SPOUSE DOB: _____

SPOUSE'S EMPLOYER: _____ WORK PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

PHARMACY: _____ PHONE: _____

HAVE YOU EVER BEEN SEEN BY A CARDIOLOGIST? YES NO NAME: _____

IS THIS ACCIDENT OR INJURY RELATED TO: AUTO JOB OTHER

DATE OF INJURY: _____

INSURANCE: _____ IS A REFERRAL REQUIRED? YES NO

Primary Card Holder's Name: _____ And DOB: _____

HOW DID YOU HEAR ABOUT HEEKIN ORTHOPEDIC SPECIALISTS?

Physician: YES NO (If yes, list name and specialty, i.e. Dr. Smith, Family Practice)

Physician Name: _____ Specialty: _____

Physician Phone: _____

Urgent Care Center: _____

Former Patient: YES NO Name: _____

Friend/family: YES NO Name: _____

Phone Book: YES NO White pages Yellow pages Online

Website: YES NO Was the website helpful? _____

Advertisement: YES NO Where was the Ad? _____

Healthfair/expo: YES NO Name and/or date of Expo _____

Other: YES NO _____

NAME: _____ DOB: _____ DATE: _____

REVIEW OF SYSTEMS:

Constitutional

- Chills
- Fatigue
- Fever
- Malaise
- Night Sweats
- Weakness
- Weight Gain
- Weight Loss

Cardiovascular

- Chest pain
- Cyanosis
- Heart Murmur
- Irregular heartbeat/
palpitations
- Leg swelling
- Syncope

Integumentary

- Contact allergy
- Itchy skin
- Rash
- Skin Infection
- Skin lesion

Metabolic/endocrine

- Cold intolerant
- Hair loss
- Heat intolerant

HEENT

- Blurred Vision
- Double Vision
- Dysphagia
- Ear drainage
- Facial pain
- Headache
- Hearing loss
- Hoarseness
- Nasal congestion
- Ringing in ears
- Vertigo
- Vision loss

Gastrointestinal

- Abdominal pain
- Constipation
- Black tarry stools
- Diarrhea
- Heartburn
- Jaundice
- Loss of appetite
- Nausea
- Vomiting

Neurological

- Difficulty walking
- Dizziness
- Poor coordination
- Memory loss
- Muscle weakness
- Paresthesia
- Seizures
- Tremors

Psychiatric

- Anxiety
- Depression
- Insomnia

Respiratory

- Chest pain(respiratory)
- Cough
- Dyspnea
- Recent infections
- Known TB exposure
- Wheezing

Genitourinary

- Dysuria
- Frequent urination
- Hematuria
- Urge incontinence
- Urinary continence

Hematologic

- Bleeding
- Bruising

Immunological

- Asthma
- Bee sting allergies
- Contact dermatitis
- Environmental allergies
- Food allergies
- Seasonal allergies

MEDICAL INFORMATION:

CURRENT MEDICATIONS:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.
11.	12.

DRUG ALLERGIES:

REACTIONS:

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

HEIGHT: _____ WEIGHT: _____

NAME: _____ DOB: _____ DATE: _____

PAST MEDICAL HISTORY:

Please select if condition applies to your medical history:

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> TB |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> High BP | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | |

Other: _____

PAST SURGICAL HISTORY

	<u>DATE</u>		<u>DATE</u>
Arthroscopic Surgery	_____	Hysterectomy	_____
Back Surgery	_____	Joint Replacement	_____
Coronary Bypass	_____	Neck Surgery	_____
Gall bladder	_____	Tonsil/Adenoid	_____
Hand Surgery	_____		

Other: _____

FAMILY HISTORY

	Father	Mother	Siblings	Children	Grandparent
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High BP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY:

Have you ever smoked cigarettes? Yes No Do you currently smoke? Yes No

--If you smoke, how many cigarettes do you smoke a day? (20 cigarettes = 1 pack)

- | | | |
|---|--|----------------------------------|
| <input type="checkbox"/> Less than 1 pack | <input type="checkbox"/> 1 Pack | <input type="checkbox"/> 2 Packs |
| <input type="checkbox"/> 3 Packs | <input type="checkbox"/> More than 3 packs | |

--If you smoke, how long have you been a smoker?

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> Less than 1 year | <input type="checkbox"/> 1-5 years | <input type="checkbox"/> 6-10 years |
| <input type="checkbox"/> 11-15 years | <input type="checkbox"/> 16-20 years | <input type="checkbox"/> More than 20 years |

Do you drink alcohol?

- | | | |
|---|---|---|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes, but no more than once a month | <input type="checkbox"/> Yes, several drinks a week |
| <input type="checkbox"/> Yes, one drink a day | <input type="checkbox"/> Yes, more than one drink a day | |

Do you regularly drink beverages containing caffeine?

- | | | |
|--|--|--|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes, but not everyday | <input type="checkbox"/> Yes, one cup a day |
| <input type="checkbox"/> Yes, 2 cups a day | <input type="checkbox"/> Yes, 3 cups a day | <input type="checkbox"/> Yes, 4 cups a day |
| <input type="checkbox"/> Yes, 5 cups a day | <input type="checkbox"/> Yes, 6 cups a day | <input type="checkbox"/> Yes, more than 6 cups a day |

Activity level: Moderate Sedentary Vigorous

Type of exercise: _____

- | | | |
|--------------------------------|---|---|
| Frequency of exercise: | <input type="checkbox"/> 2-3 times/week | <input type="checkbox"/> 3-4 times/week |
| <input type="checkbox"/> Daily | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional |

Name: _____ DOB: _____

Authorization and Assignment of Benefits:

For the services rendered and those about to be rendered, I hereby assign to Heekin Orthopedic Specialists, all medical benefits otherwise payable to me under the described policy not to exceed the charges made to such service. I further authorize the above mentioned insurance company to pay said benefits directly to Heekin Orthopedic Specialists and further direct that they make no payment to me. In the event that I receive payment from the insurance company, I agree to endorse such payment to Heekin Orthopedic Specialists. I understand that I am directly and primarily responsible to Heekin Orthopedic Specialists for the usual and customary fee for the services rendered to me. I realize that if my insurance company fails to pay or there is a delay (more than 90 days) in their paying, it is my sole responsibility to promptly pay my bill directly. I also realize that any services not covered under my insurance company will be my responsibility to pay in full. I further understand and agree if I fail to make prompt and timely payments, I will be directly responsible for any and all cost of collection including the filing fees as well as reasonable attorney fees. I hereby authorize Heekin Orthopedic Specialists to release to my insurance company, any information acquired including the diagnosis and the records in the course of my treatment.

Signature

Date

Medicare Certification for Payment: (Lifetime Authorization)

I certify that the information given by me in applying for payment under the title XVII of the Social Security Act is correct. I authorize any holder of medical and other information about me to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be payable to Heekin Orthopedic Specialists for my behalf. I also assign the benefits payable for physician service to the physician furnishing the services and authorize such physician to submit a claim to Medicare in my behalf.

Signature

Date

Heekin Orthopedic Specialists
Statement of Policies

The following policies are established for mutual convenience and benefit. Please read them carefully and sign at the bottom to indicate your agreement of the statement of policies.

1. **Heekin Orthopedic Specialists** strictly provides orthopedic services only. Patients are expected to have or arrange for a Primary Care Physician. Our practice does not treat chronic pain.
2. **Deductibles and Co-Pays** are payable at the time of service. Any previous balance is expected to be paid at time of service.
3. Patients are responsible for obtaining referrals and authorizations for services rendered at Heekin Orthopedic Specialists
4. If you are unable to keep a scheduled clinic appointment, please call during normal business hours, 24 hours in advance to cancel the appointment. Failure to do so may incur a \$30.00 charge to your account for the missed appointment.
5. There is a \$25.00 fee for all disability, FMLA, and other forms/ paperwork that you need to have filled out by the physician. We may ask that you make an appointment to complete these forms.
6. There is a fee for any reports or records requested by attorneys, insurance companies, disability companies, etc...This charge will be determined by the information requested.
7. **Prescription Policies:**
 - a. If you are in need of a refill, please have your pharmacy fax a request to 904-634-0203. Please allow 48 to 72 hours.
 - b. No refills will be given on Friday after 2:00 PM
 - c. No pain medication will be given to post-operative patients after 90 days of surgery.
 - d. Our physicians **DO NOT** prescribe pain medications to chronic pain patients. Patients with chronic pain syndrome are referred to pain management specialists for long term management.

I acknowledge that I have carefully read and understand the Statement of Policies, and agree to abide by them.

Name (please print)

DOB

Signature

Today's Date