LONGVIEW ORTHOPAEDIC CLINIC ASSOCIATION

Personalized Medicine. Quality Care.

Patient Name: _____ **Date of Birth**: _____

Age: _____ Gender: _____ Social Security Number: _____

Physical Address: _____

Mailing Address: _____

Preferred Phone: _____ ❑Home ❑Mobile ❑Work

Alternate Phone: _____ ❑Home ❑Mobile ❑Work

Email: _____ Employer: _____

Primary Care Physician: _____ Preferred Pharmacy: _____

Emergency Contact, Relationship & Phone: _____

RESPONSIBLE PARTY IF PATIENT IS A MINOR OR STUDENT

Father's Name & Address: _____

Father's DOB & SSN: _____

Father's Phone & Employer: _____

Mother's Name & Address: _____

Mother's DOB & SSN: _____

Mother's Phone & Employer: _____

_____

How did you hear about Longview Orthopaedic Clinic:

❑Physician Referral ❑Google ❑Facebook ❑Family/Friends ❑Other: _____

Authorization

I hereby assign to my physician all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance. I hereby authorize my physician to furnish information to my insurance carrier concerning my illness and treatments.

The physicians of Longview Orthopaedic Clinic Association disclose that we do have financial interests in the following rehabilitation providers from which you may receive care: Highland Pines Skilled Nursing Facility, Haven Care Nursing Home, Bethany Home Health, Choice Home Health, Premier Home Health, The Willows, and Longview Orthopedic Clinic Physical Therapy.

Patient Signature: _____ Date: _____

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Patient Health History Form

Patient Name: _____ **DOB**: _____

Primary Care Physician: _____ Physician who referred you: _____

Race: ❑African-American ❑Hispanic ❑Asian ❑White ❑Other: _____

Marital Status: ❑Single ❑Married ❑Separated ❑Divorced ❑Widowed

Occupation: _____ ❑Full-time ❑Part-time ❑Seasonal ❑Unemployed

Reason for visit today: _____

How long have you had this problem? _____ Days _____ Weeks ____ Months ___ Years

How did this problem happen? _____

_____

_____

Is this problem the result of a ❑work-related accident ❑car accident
If yes: Date of accident: _____ Place of accident: _____
If yes: Are you currently working? ❑ Yes, full duty ❑Yes, light duty ❑No

Have you received care from another healthcare provider for this problem? ❑ Yes ❑No
If yes, whom & when: _____

Social History

Use tobacco: ❑Yes ❑No
If yes, type: _____ How many per day _____ How long (years) _____
If you have quit tobacco, how long ago did you quit? _____

Use alcohol: ❑Yes ❑No
If yes, type:_____ Amount per day or week: _____

Use recreational drugs: ❑Yes ❑No
If yes, type: _____ Amount per day or week: _____

Have you ever been treated for a drug, alcohol or opioid addiction? ❑Yes ❑No
If yes, substance: _____ Dates: _____

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Patient Name: _____ **DOB**: _____

Height: ____ ft ___ inches **Weight**: ____ lbs. ❑Right-handed ❑Left-handed

Past Medical History

Diabetes	❑Yes	❑No	High blood pressure	❑Yes	❑No
Heart disease	❑Yes	❑No	High cholesterol	❑Yes	❑No
Blood clots	❑Yes	❑No	Stroke	❑Yes	❑No
Depression	❑Yes	❑No	Kidney disease	❑Yes	❑No
COPD	❑Yes	❑No	Asthma	❑Yes	❑No
Arthritis	❑Yes	❑No	Osteoporosis	❑Yes	❑No
Cancer	❑Yes	❑No			

If yes, what type and when? _____

_____

Other conditions: _____

Past Surgical History & Dates

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Are you allergic to Latex: ❑Yes ❑No

Have you/anyone in your family been diagnosed with malignant hyperthermia? ❑Yes ❑No

Are you currently classified as disabled through Social Security? ❑Yes ❑No

If yes, please list the condition for which you are disabled: _____

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Patient Name: _____ **DOB**: _____

Medications

Medication Name	Dosage	Times taken per day

Medication Allergies

Allergic to	Type of Reaction

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Patient Name: _____ **DOB**: _____

Review of Systems

*Please check if you have had any of the following **in the past 12 months**:*

Constitutional

❑ Weight gain ❑Weight loss ❑Night sweats ❑Chills ❑Fever

Skin

❑Easy bleeding ❑Easy bruising ❑Any rashes

Ear, Nose, Throat & Eyes

❑Vision changes ❑Change in smells ❑Dizziness ❑Hearing changes

Respiratory

❑Shortness of breath ❑Wheezing ❑Cough ❑Increased mucus

Cardiovascular

❑Chest pain ❑Palpitations ❑Heart murmur ❑Feet swelling

Gastrointestinal

❑Nausea ❑Vomiting ❑Diarrhea ❑Dark/bloody stools

Musculoskeletal

❑Cramps ❑Joint pain ❑Joint swelling ❑Stiffness in the morning ❑Weakness

Nervous System

❑Numbness/tingling in feet ❑Numbness/tingling in hands ❑Problems sleeping

Genitourinary

❑Blood in urine ❑Incontinence (bowel or bladder) ❑Urinary tract infection

For Females: ❑Abnormal vaginal bleeding ❑Breast biopsy ❑Nipple discharge

Last menstrual period: _____

For Males: ❑Prostatitis ❑Difficulty urinating

Date of last prostate exam/PSA: _____ Results: _____

I hereby acknowledge that the above information is complete and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

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Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Longview Orthopaedic Clinic to use and/or disclose certain protected health information (PHI) about me to _____ (spouse, child, caregiver, etc.).

This authorization permits Longview Orthopaedic Clinic to use and/or disclose individually identifiable PHI about me, including but not limited to dates of service, types of services, and the origin of the information. This information may be used or disclosed so that I and my approved delegates may make informed decisions about my care.

This authorization will expire on _____.

Longview Orthopaedic Clinic will not receive payment or other remuneration from a third party in exchange for using or disclosing this PHI.

I do not have to sign this authorization in order to receive treatment from Longview Orthopaedic Clinic. In fact, I have the right to refuse to sign this authorization. When my PHI is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at rshort@longvieworthopedic.com.

Longview Orthopaedic Clinic will notify any patient of a potential breach of HIPAA privacy information as soon as the breach is identified.

Signed by: _____ Relationship to Patient: _____

Patient or Guardian Signature

_____ Date: _____

Print Patient's Name

_____

Print Name of Parent or Guardian

- *Patient/guardian must be provided a signed copy of this authorization*

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Acknowledgment of Receipt of Notice of Privacy Practices

I, _____, acknowledge that I have received a copy of the Longview Orthopaedic Clinic Association (LOCA) Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Patient Legal Representative (if applicable) Date

_____ _____
Printed name of Legal Representative Relationship to Patient

For LOCA Use Only

LOCA has made the good following good faith efforts to obtain the above-referenced individual's written acknowledgment of receipt of the Notice of Privacy Practices:

(identify the efforts taken to obtain acknowledgment including reasons why it was not obtained)

_____
_____
_____
_____

Name of LOCA Representative: _____

Date placed in patient chart: _____

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Consent to Contact

You agree, in order for us to service your account, collect any amounts you may owe or to survey your satisfaction with our services, that we may contact you by telephone at any telephone number associated with your account, including mobile phone numbers, which could result in charges to you. We may also contact you by sending messages or emails using any email address you provide to us. Methods of contact may include pre-recorded/artificial voice messages, use of automated dialing devices or third-party applications.

I have read this disclosure and agree that the Lender/Creditor may contact me as described above.

Signature: _____ Date: _____

I grant Longview Orthopedic permission to speak with the following people concerning my financial account:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Signature: _____ Date: _____