Markbreiter Orthopedics, Inc.- New Patient Information Form

Date:_____
Last Name:_____ First Name (Legal):_____M.I._____
Address:_____City:_____State:_____Zip Code:_____
Social Security#:_____Date of Birth:_____ Age:_____
Home#:_____ Cell#:_____
Work#:_____ Email:_____
Sex:❑M ❑F Marital Status: ❑Single ❑Married ❑Widowed ❑Divorced ❑Separated
Race:_____ Ethnicity:_____ Pref Language:_____

Emergency Contact

Name:_____Relationship:_____Phone#:_____
If Patient is a minor-parent's social sec#_____
Referred by: ❑Primary Physician ❑Other Physician ❑Friend ❑Other _____
Your Primary Care Physician:_____City_____State_____
Referring Physician:_____Address_____
City:_____ State:_____ Zip Code:_____ Phone#:_____

Employer Information

Name:_____
Address:_____City:_____
State:_____ Zip Code:_____ Phone#:_____
Occupation:_____

Current Problem

Please briefly describe:_____
_____
Is problem on your: ❑Right Side ❑Left Side Date of onset:_____

Health Insurance Information

Primary

Carrier:_____ Name of Insured (Policyholder) :_____
Address:_____ ID Number:_____
City:_____ State:_____ Zip Code:_____
Insured's Employer:_____ SS#:_____ DOB (mm/dd/yy)_____

Secondary

Carrier:_____ ID Number:_____
Name of Insured (Policyholder) :_____ SS#:_____DOB (mm/dd/yy)_____
Insured's Employer:_____
Address:_____ City:_____ State:_____ Zip Code:_____

I hereby authorize that payment be made directly to my physician on all insurance submitted by Markbreiter Orthopedics, Inc for covered services rendered. I understand I am financially responsible for any non-reimbursed amounts of my bill. I authorize release of any pertinent medical records and/or X-Rays concerning my care to insurance companies, and/or my attorney of record, and/or Markbreiter Orthopedics, Inc. I also authorize release of medical data that includes re-disclosure of medical information obtained from other providers. I permit a photostat copy of this authorization be used in place of the original.

I certify that the information I have reported with regard to my insurance coverage is correct.

Signature:_____Date:_____

Medical History Form

Are you: ❑Right Handed ❑Left Handed

Describe any medical treatment you have already received for this problem: _____

_____

List any previous surgeries and dates (Not necessarily related to present problem)

Date	Surgery	Date	Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List All Medications and Vitamins you are Currently Taking

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any Allergies to Medications

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please Complete the following to the best of your ability

Height:_____ Weight:_____ Blood Pressure:_____

Do You Smoke: ❑Yes ❑No How Much?_____ Do you drink?: ❑Yes ❑No Frequency:_____

List All Present Medical Problems

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you ever had problems with

Asthma	❑Yes	❑No	Hepatitis	❑Yes	❑No
Bladder	❑Yes	❑No	Hiatal Hernia	❑Yes	❑No
Bleeding Tendencies	❑Yes	❑No	High Blood Pressure	❑Yes	❑No
Bowels	❑Yes	❑No	Kidneys	❑Yes	❑No
Breathing Difficulties	❑Yes	❑No	Liver Disease	❑Yes	❑No
Cancer	❑Yes	❑No	Lungs	❑Yes	❑No
Circulation	❑Yes	❑No	Osteoporosis	❑Yes	❑No
Coordination	❑Yes	❑No	Prostate Problems	❑Yes	❑No
Diabetes	❑Yes	❑No	Shortness of Breath	❑Yes	❑No
Digestion	❑Yes	❑No	Substance Abuse	❑Yes	❑No
Dizziness	❑Yes	❑No	Thyroid	❑Yes	❑No
Emotional Problems	❑Yes	❑No	Ulcer Disease	❑Yes	❑No
Epilepsy	❑Yes	❑No	Vision	❑Yes	❑No
Gall Bladder	❑Yes	❑No	Water Retention	❑Yes	❑No
Gout	❑Yes	❑No			
Hearing Problems	❑Yes	❑No			
Heart Problems	❑Yes	❑No			
• Chest Pains	❑Yes	❑No			
• Palpitations	❑Yes	❑No			

Other:_____

_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare options. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patients signature in acknowledgement of this Notice Privacy Acknowledgement, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____

*Fellow of the American Board of Orthopedic Surgeons

OWNERSHIP DISCLOSURE STATEMENT

This is to advise you that the doctors have ownership interests in treatment of Surgery Centers to which you may be referred. This is to further advise you that you may choose any facility available for the purpose of obtaining the particular procedure or test being performed and to let the physician know if you wish to choose a certain facility or center other than the one which you have been referred. The facilities or centers whereby the physicians have ownership interest may include, but are not limited to: Lakewood Surgery Center.

I have read and under the above.

_____
(Patient Signature)

_____
(Date)