Connolly Orthopedics
and sports medicine

Patient Name: _____ Today's Date:_____

Last, First, M.I

Primary Language Spoken: _____

Please **CIRCLE** yes or no to the following questions

1. Were you seen in the Emergency Room? YES / NO
   If yes, which hospital? _____
2. Is this a work related injury? YES / NO
   If yes, what is your date of injury? _____
3. Will workers compensation be paying for this injury? YES / NO
4. Is this injury the result of a Motor Vehicle Accident? YES / NO
5. Is there a lawsuit involved with your injury? YES / NO
6. Are you disabled? YES / NO
7. Are you able to have an MRI? YES / NO
8. Do you have a pacemaker or defibrillator? YES / NO
9. Do you have any recent Xrays/MRIs of today's problem? YES / NO
   If yes, where were they done? _____

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Review of Systems

CIRCLE all that apply

General	Weakness/Weight Loss/ Weight Gain
Eye	Visual Impairment/Blindness
Ear	Trauma/Deafness
Heart	Circulation/Chest Pain
Lung	Breathing/Cough
Gastrointestinal	Digestion
Urinary	Blood in Urine/Burning
Musculoskeletal	Joint/Back Pain
Neurological	Dizziness/Weakness
Psychiatric	Anxiety/Depression
Endocrine	Increased Thirst
Blood/Lymph	Anemia/Bruising/Autoimmune
Allergies	Hay Fever/Asthma
	All Systems Reviewed and Negative

Surgical History

CHECK all that apply	**Year**
☐ Back/ Disc	
☐ Fracture/Tendon Repair	
☐ Total Joint Replacement	
☐ Cancer	
☐ Gallbladder	
☐ Appendix	
☐ Open Heart/ Heart Valve	
☐ Pacemaker/Defibrillator	
☐ Hysterectomy	
☐ Prostate	
☐ Cesarean Section	
☐ Other	

Medical History

CHECK all that apply

☐ Asthma/COPD
☐ Arthritis
☐ Back Disorders
☐ Bleeding Disorders
☐ Blood Clots
☐ Broken Bone – Type _____
☐ Cancer - Type _____
☐ Colitis/Diverticulitis
☐ Diabetes
☐ Gout
☐ Heart Disease
☐ Heart Attack – Year _____
☐ Hepatitis
☐ Hiatal Hernia
☐ High Blood Pressure
☐ HIV
☐ Kidney Disease/Stones
☐ Liver Disease
☐ Stroke
☐ Substance Abuse
☐ Thyroid Disease

Family History

CHECK all that apply	**Relation to Patient**
☐ AIDS/HIV	
☐ Alcoholism/Substance Abuse	
☐ Arthritis	
☐ Bleeding Disorders	
☐ Cancer	
☐ Diabetes	
☐ Gout	
☐ Heart Disease	
☐ Kidney Disease	
☐ Liver Disease	
☐ Stroke	
☐ TB	

Patient Signature: _____

For Office Use Only:

Provider Signature_____

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Patient Name: _____ Today's Date:_____

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Please Print All Information

Date of Birth ____/____/_____ **Age**_____

Male _____ **Female**_____

Weight_____ **Height** _____**ft** _____**in**

Social History - Please **CIRCLE** all that apply

Married/Single/Divorced/Widow

Currently Living Alone: YES / NO

Do you Drink Alcohol: YES / NO

Occasional/Social/Moderate/Heavy

Do you Smoke: YES / NO / NEVER

Packs Per Day? _____

When Did You Quit? _____

Reason for Today's Visit?

(Specific Body Part and Side)

_____

_____

_____

Allergies

Please List all or write none in the lines below

_____

_____

_____

Primary Care Physician

Name:_____

Phone: _____

Cardiologist

Name:_____

Phone:_____

Pharmacy

Name:_____

Phone:_____

Address:_____

Current Medications

List Name/Dosage/Frequency – If None, Write NONE on the Lines below

_____
_____
_____
_____
_____
_____
_____
_____

OR – Attached Copy of Med List

Do you take a Blood Thinning Medication? YES/NO

Medication Name: _____

Patient Signature: _____

Today's Date:_____

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Today's date: _____EMAIL ADDRESS: _____

Patients
Name_____
(LAST) (FIRST) (MIDDLE)

Local address_____City_____State_____Zip_____

Billing address_____City_____State_____Zip_____

Home Phone **(____)**_____ Cell Phone (_____)_____ Local Phone (_____)_____

Age_____ Date of Birth _____/_____/_____ Social Security #_____
MO / DAY / YEAR

Marital Status: Single Married Divorced Separated Widowed
Minor
If Minor, Responsible Parties: _____

Employers Name_____

Employers Address _____City_____State_____Zip_____

Business phone (___) _____Occupation_____

Person to Notify in Case of Emergency, Other Than Spouse_____
PHONE (_____)_____

Financial Responsibility

All Professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. All unpaid balances will be considered delinquent 60 days from the date of service. Any delinquent accounts can be referred to a collection agency and will incur the cost of collection including reasonable attorney fees.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Connolly Orthopedics for medical services rendered to myself and/or my dependent's regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Connolly Orthopedics to: (1) release any information with other physicians when it is necessary for treatment; (2) release any information necessary to insurance carriers regarding my illness and treatments; (3) process insurance claims generated in the course of examination or treatment; and (4) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested Connolly Orthopedics on behalf of myself and/or my dependent's, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

PRESCRIPTIONS RENEWAL POLICY **PLEASE, ALLOW 2-3 BUSINESS DAYS TO RENEW YOUR PRESCRIPTIONS**.

It is our policy to renew prescriptions ONLY during business hours Monday through Friday 8 am to 4:30 pm. Prescriptions WILL NOT be filled after hours or on weekends.

Patient/Responsible Party Signature _____ Date _____

HIPAA COMPLIANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of protected health information has been identified as a national problem causing some patients inconvenience, aggravation and money. We want you to know that all of our employees/managers periodically receive training to assist them in understanding and complying with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with a particular emphasis on the "Privacy Rule". We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

When it is appropriate and necessary, we provided the minimum necessary information to only those we feel are in need of your health care information. Other entities may have indirect treatment relationships with you (such as the physician reading your x-ray) and we may have to disclose personal health information for purposes of treatment or payment. These entities are most often not required to obtain patient consent.

You may refuse, in writing, the consent to the use or disclosure of your personal health information. Under this law, we then have the right to refuse to treat you should you refuse to disclose your personal health information. At any time in the future, you may request to refuse all or part of disclosure to your personal health information. However, you may not revoke actions that have already been taken which relied on this or a previously signed consent.

It is our policy to determine appropriate uses of personal health information in accordance with the governmental rules, laws and regulations. We want to ensure that our Center never contributes in any way to the growing problem of improper disclosure of personal health information. We have implemented a program we believe will help us prevent any inappropriate use of personal health information.

We also know that we are not perfect! Because of this fact, our policy is to listen to our patients and employees without any thought of penalty if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

If you have any questions, please ask to speak with our Privacy Officer.

May we leave a message on your answering machine regarding your health information and/or email? Yes No

email address: _____

Who may we speak to regarding your health information, if you are not available?_____

_____

_____

Name / Relationship ***Name / Relationship***

I acknowledge I have received a copy of the **Connolly Orthopedics & Sports Medicine** Notice of Privacy Practices.

_____ _____

Signature of Patient or Authorized Person Date