REGIONAL
ORTHOPAEDICS & PAIN MANAGEMENT, PLLC

Name: ______________________________ Date of Birth: __________ Age: _____

SS#: ______________ **Sex**: ( ) Male ( ) Female **Marital Status**: ____________________

Name of Parent (if child): ______________________________

Physical Address: ______________________________ City: __________ State: ___ Zip: _______

Mailing Address: ______________________________ City: __________ State: ___ Zip: _______

Home Phone: ____________________ Cell Phone: ______________________________

Emergency Contact: Name & Relationship: ____________________ Phone: ______________

Please note when completing information below if patient is a child please provide parent or guardian information:

Occupation: ______________________________ Business Phone: ____________________

Employed By: ______________________________

Employers Address: ______________________________

INSURANCE INFORMATION

IS THIS CONDITION/INJURY: WORK RELATED? ( ) YES ( ) NO AUTO ACCIDENT? ( ) YES ( ) NO

Primary Insurance: ____________________ Phone: ____________________

Policy/ID#: ______________ Plan#: ______________ Group#: ______________

Policyholder's Name: ____________________ Relationship: ____________________

Policyholder's Date of Birth: ____________________

Secondary Insurance: ____________________ Phone: ____________________

Policy/ID#: ______________ Plan#: ______________ Group#: ______________

Policyholder's Name: ____________________ Relationship: ____________________

Policyholder's Date of Birth: ____________________

UNIFORM ASSIGNMENT AND RELEASE OR INFORMATION STATEMENTS

I hereby authorize Regional Orthopaedics & Pain Management, PLLC to release any medical information to my insurance company to process my insurance claim. I understand that I am financially responsible for all charges not paid by the insurance company including any and all co-payments, co-insurance, deductibles, collection costs, returned check fee of $25.00, or attorney fees. I understand that it is my responsibility to inform Regional Orthopaedics & Pain Management, PLLC of any changes in the information on this form.

I assign to Regional Orthopaedics & Pain Management, PLLC sufficient monies and benefits to which I may be entitled from the government agencies, insurance carriers, or others who are financially liable for my medical care, to cover the costs of the care and treatment to me or my dependent.

For patients entitled to Medicare Benefits: I certify that the information given by me in applying for payment under the title XVIII of the Social Security Act is correct. I authorize any holder of my medical or other information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I request that payment of authorized benefits be made on behalf to Regional Orthopaedics & Pain Management, PLLC for services furnished to me by the providers of the group.

Patient's Signature: ______________________________ Date: ____________________

Print Name: ______________________________ Relationship: ____________________

If signed by a representative, please print name and relationship to patient above

REGIONAL ORTHOPAEDICS & PAIN MANAGEMENT, PLLC

Date: ____________________

Name: ____

DOB: ____________________

I, acknowledge that I received the written Notice of Privacy Practices and Record Disclosure.

- ☐ The patient's condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient's condition improves.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone
  - ☐ Leave message with detailed information
  - ☐ Leave message with call back number
- ☐ Work Telephone
  - ☐ Leave message with detailed information
  - ☐ Leave message with call back number
- ☐ Written Communication
  - ☐ Can mail to home address
  - ☐ Can mail to work address
  - ☐ Can fax to this number: ________________________________

I consent to have my personal health information disclosed to my:

- ☐ Spouse: ______________________________
- ☐ Parent: ______________________________
- ☐ Parent: ______________________________
- ☐ Other: ______________________________

____

Signature

PATIENT CLINICAL INFORMATION SHEET

Patient Name:

____

Bradley Wiener, MD

Today's Date__________ Date of Birth__________

General Health Review

Medical History (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illnesses, etc.)

______________________ __________________________ ________________________

______________________ __________________________ ________________________

Allergies (include medication and food allergies)

______________________ __________________________ ________________________

______________________ __________________________ ________________________

Surgical History

______________________ __________________________ ________________________

______________________ __________________________ ________________________

Hospitalization History (list any hospitalization for reasons other than any surgeries listed above)

Date(s)____________ Reason____

Date(s) ___________ Reason____

Current Medications (include vitamins and birth control pills, if applicable)

Name of Medication:	Dosage:	Frequency:	Taken for:	Other Information for this medication

Preferred Pharmacy:

Name___________________________________Location__________________________________

Rx History Consent:

Do you give permission for us to view your prescription history from an external source? ___Yes ___No

Patient or Authorized Person Signature: ____

Review of Systems

	NO	YES		NO	YES
General/Constitutional			**Cardiovascular**		
Change in appetite			Chest pain at rest		
Chills			Chest pain with exertion		
Fever			Irregular heartbeat		
ENT			Shortness of breath		
Decreased hearing			**Gastrointestinal**		
Sore throat			Abdominal pain		
Swollen glands			Diarrhea		
Endocrine			Nausea		
Cold intolerance			Vomiting		
Excessive thirst			**Genitourinary**		
Heat intolerance			Blood in urine		
Weight loss			Difficulty urinating		
Respiratory			Frequent urination		
Cough			Skin		
Shortness of breath at rest			Dry skin		
Shortness of breath with exertion			Itching		
Wheezing			Rash		
Psychiatric			**Neurologic**		
Anxiety			Dizziness		
Depressed Mood			Fainting		
Difficulty sleeping			Headache		
Substance Abuse, including alcohol If yes, please explain:			***Other condition for any listed system:***		

Family History- *please complete the boxes below*

Relative:	Alive/Age	Deceased	Diabetes	Hyper-tension	Heart Disease	Stroke	Cancer	Unknown Or Other (Please explain)
Mother								
Father								

Siblings	# brothers____ # sisters ____	Healthy ? Yes □ No □	*If no, please briefly explain:*
Children	# sons ____ # daughters ____	Healthy ? Yes □ No □	*If no, please briefly explain:*

Work Status: Are you currently working? _____Yes _____No

Tobacco Use

Do you presently smoke cigarettes or use tobacco in any form? Yes_____ No_____
If current smoker:
How often do you smoke cigarettes: _______every day _________some days
How many cigarettes a day do you smoke?:
______5 or less _____6 to 10 _____11 to 20 _____ 21 to 30 ______31 or more
How soon after you first wake up do you smoke your first cigarette?
_____within 5 minutes _____6 to 30 minutes _____31 to 60 minutes _____ after 60 minutes
Are you interested in quitting?
_____ Ready to quit _____ Thinking about quitting _____ Not ready to quit

If not a current smoker, did you <u>*ever*</u> smoke cigarettes or use tobacco in any form? Yes_____ No_____
How many packs (did) you smoke a day? _____ For how many years? _____

Primary Care

To assist us with your care, please provide the name and location of your Primary Care Physician:

Name________________________________ Location(City/State)_____________________________

Phone Number ________________________________

Would you like us to send the note(s) from today's visit to the above PCP? ____Yes ____No

Would you like us to send the note(s) from today's visit to any other provider? If yes, please list name/address:

____

____

We appreciate your assistance with obtaining your complete medical history. All of the information contained on this form is part of your confidential medical record with our office. The medical assistant will privately review with you in the exam room during today's visit.