SOUTHWEST ORTHOPEDIC GROUP, LLP

DATE: ________________________ **DR. NAME:** _________________________

PATIENT DATA

____ SOCIAL SECURITY NO: ____________________
Last Name First Name Middle

_____________________________ ______________ MALE OR FEMALE **Marital Status**: M S W D
Date of Birth Age

____ HOME PHONE NO.: _________________________
Home Address Apt. No.
____ CELL PHONE NO.: _________________________
City State Zip Code

BUSINESS PHONE: _________________________

Occupation: ______________________________

Referred By:

____ OFFICE NO.: ______________________________

EMERGENCY CONTACT INFORMATION:

____ PHONE NO.: _____________________________
NAME
RELAIONSHIP: ____

EMPLOYER INFORMATION:

____ PHONE NO.: _________________________
EMPLOYER NAME

____ ______________________________________
Address City State Zip Code

GUARANTORS INFORMATION:

____ SOCIAL SECURITY NO: ____________________
Last Name First Name Middle

Date of Birth ______________________________Patient's Relationship to Policy Holder: _______________________________

____ HOME PHONE NO.: _________________________
Home Address Apt. No.
____
City State Zip Code

INSURANCE INFORMATION

PRIMARY INSURANCE:

____ Customer Service No: _________________________
Name of Primary Insurance

______________________________ ___________________________
ID NUMBER GROUP NO.

SECONDARY INSURANCE:

____ Customer Service No: _________________________
Name of Secondary Insurance

______________________________ ___________________________
ID NUMBER GROUP NO.

AUTHORIZATION TO PAY BENEFITS OT PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY OTHERWISE PAYALE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT RELEASE ME FROM MY PERSONAL RESPOBSIBILITY FOR PAYMENT OF ALL CHARGES WITHIN 50 DAYS. AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

____
SIGNATURE DATE

JEFFREY E. BUDOFF, M.D.

Patient Name__________________________________ Today's Date______________

Age____________ Birthdate_________________ Sex M F

I am: Right-Handed Left-Handed Injured Arm: Right Left

Occupation_______________________________________Employer________________________
Major Hobbies____
Referring Physician and **Phone Number**____
Date of Injury_____________________
Reason for Your Visit Today____
____

PMH: Please Circle Any of the Following Conditions That You **CURRENTLY** Have:

Insulin Dependent Diabetes	High Blood Pressure	Heart Disease
Non-Insulin Dependent Diabetes	Blood Clots	Heart Attacks
Hypothyroidism/Hyperthyroidism	Bleeding Disorder	Lung Disease
Reaction to Anesthesia	Kidney Disease	Hepatitis
HIV/AIDS	Peptic Ulcer Disease	Liver Disease
Rheumatoid Arthritis	Drug Abuse	Alcoholism
Asthma	Psychiatric Disorder: What type?_____________	

Cancer: What Type?_________________________________ Are You Pregnant: Y N

Any Other Medical Problems?____

PSH: Please List Each Surgery (Procedure and Date) That You Have Had:
____
____
____

Allergies: Please List Any MEDICATIONS That You Are Allergic to and What Happens When You Take Them:
____
____
____

Medications: Please List ALL Medications You Take. Including Aspirin, Motrin, etc:
____
____
____

Review of Systems: Please Circle Any of the Following that You **CURRENTLY** Have:

Fever	Dizziness	Fingertip Cold Intolerance
Rash	Depression	Fingertip Ulcers
Blood in Stool	Productive Cough	Shortness of Breath
Tingling or Numbness in your Feet		Difficulty Urinating
Tingling or Numbness in your Hand		Chest Pain

Joint Aches: Which Joints? ___________________________________

Social History:

Do You Smoke?	Y	N	How much? ____________
Do You Drink Alcohol?	Y	N	How much? ____________
Do You Use Recreational Drugs?	Y	N	What Kind? ____________

Family History: Please Circle Any of the Following Medical Problems in Your Immediate Family (Mother, Father, Sister, Brother):

Reaction to Anesthesia	Hypertension	Rheumatoid Arthritis
Bleeding Problems	Heart Problems	Diabetes
HIV/AIDS	Lung Disease	Cancer: What Type? _______

Other Diseases that Run in the Family:____

Please List Any Other Information That You Feel The Doctor Needs to Know:

____

____

____

Are You Currently Working? Y N

Are You On Any Restrictions? If yes, please describe.

____

____

SOUTHWEST ORTHOPEDIC GROUP, LLP

Review of Notice of Privacy Practices

Acknowledgement:

I acknowledge that I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

______________________________ ________________

Patient or Personal Representative Signature | Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: ______________________________.

Financial Policy Statement

It is the policy of Southwest Orthopedic Group, L.L.P. to bill your insurance carrier as a courtesy to you; however, you are responsible for the entire bill. We require that arrangements for payment of your estimated share be made today. The insured/patient is responsible for any co-payments at the time service is rendered. If your insurance carrier does not remit payment within sixty (60) days, the balance will be due in full from you. If your insurance pays in excess of the balance of your account, we will refund the credit.

If any payment is made directly to you for services billed by Southwest Orthopedic Group, L.L.P., you recognize an obligation to promptly remit same to Southwest Orthopedic Group, L.L.P.

The above does not apply for those patients that are considered Workers' Compensation. However, be advised as a Compensation patient that you may be held responsible for your charges in the event that your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Southwest Orthopedic Group, L.L.P., I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.
The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

___________________________________ ___________________________________

Patient or Responsible Party | Date