Franklin
ORTHOPAEDICS
& SPORTS MEDICINE
Trusted expertise... for your active lifestyle

MEDICAL INFORMATION

TODAY'S DATE: _____

PATIENT'S NAME: _____ **AGE:** _____ **DATE OF BIRTH:** _____/_____/_____

WHO SENT YOU HERE FOR A CONSULTATION? _____

A. YOUR CURRENT PROBLEM (*PLEASE ANSWER AS COMPLETELY AS POSSIBLE)*

WHY ARE YOU HERE TODAY? _____

_____

WHAT DATE DID THIS PROBLEM BEGIN? (*BE AS SPECIFIC AS POSSIBLE)* _____

HOW DID THIS PROBLEM BEGIN? _____

_____

MY PROBLEM IS: *(CHECK ALL THAT APPLY)* ☐ CONSTANT **OR** ☐ INTERMITTENT ☐ MILD ☐ MODERATE **OR** ☐ SEVERE

MY PAIN FEELS: *(CHECK ALL THAT APPLY)* ☐ SHARP ☐ DULL ☐ BURNING ☐ ACHING ☐ THROBBING ☐ OTHER: _____

MY OTHER SYMPTOMS ARE: *(CHECK ALL THAT APPLY)*
☐ NONE ☐ FEVER ☐ CHILLS ☐ WEIGHT LOSS ☐ NUMBNESS ☐ TINGLING ☐ SWELLING ☐ LOCKING ☐ GIVING WAY

WHAT MAKES YOU FEEL BETTER? _____

WHAT MAKES YOU FEEL WORSE? _____

HAVE YOU TRIED ANY MEDICINE FOR THIS PROBLEM? (INCLUDING OVER-THE-COUNTER MEDICATION) ☐ **YES** ☐ **NO**
IF YES, PLEASE LIST MEDICATON YOU HAVE TRIED _____
DID IT HELP? ☐ **YES** ☐ **NO**

B. YOUR MEDICAL HISTORY (*PLEASE ANSWER AS COMPLETELY AS POSSIBLE)*

PLEASE LIST ALL OF YOUR PAST AND CURRENT MEDICAL PROBLEMS: _____

_____

PLEASE LIST YOUR PREVIOUS SURGERIES & DATES OF SURGERY? _____

PLEASE LIST ANY MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY? _____

_____

DO YOU SMOKE TOBACCO? ☐ **YES** ☐ **NO** DO YOU DRINK ALCOHOL ☐ **YES** ☐ **NO**

DO YOU HAVE ANY OTHER MEDICAL CONDITIONS OR SYMPTOMS THAT YOU HAVE NOT ALREADY MENTIONED? ☐ **YES** ☐ **NO**
IF YES, PLEASE LIST CONDITIONS AND/OR SYMPTOMS: _____

_____

PLEASE LIST ALL CURRENT MEDICATIONS: _____

_____

DO YOU HAVE ANY DRUG ALLERGIES? ☐ **YES** ☐ **NO** IF YES, WHAT MEDICATIONS ARE YOU ALLERGIC TO: _____

_____

Welcome To
Franklin Orthopaedics & Sports Medicine
Trusted Expertise... for your active lifestyle

For office use only:

CHART #_____

DATE _____

PATIENT INFORMATION

Patient Name: (Last) (First) (Middle) □ M □ F

SS#: Home Address:

City: State: Zip Code: Birth Date: Age:

Home Phone ( ) Cell Phone: ( ) Work Phone: ( )

Email: Can we email newsletters about orthopaedic care ? ☐ YES ☐ NO

Marital Status: □ Single □ Married □ Divorced □ Widowed Spouse's Name:

Patient's Employer: Employer's Address:

RESPONSIBLE PARTY (BILL TO) INFORMATION
(Complete this section ONLY if someone *other* than the patient is financially responsible)

Responsible Party: (Last) (First) (Middle) □ M □ F

Address:

City: State: Zip Code:

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( )

SS# Relationship to Patient: Birth Date: / /

Name of Employer: Email:

EMERGENCY CONTACT INFORMATION

Name: Relationship:

Home Phone: ( ) Cell Phone: ( ) Work Phone: ( )

REFERRAL INFORMATION

Who referred you to our office? □ Family Physician: □ Friend: □ Family:

□ Advertisement (Please list source): _____ □ Health Fair □ Website □ Special Event :_____

INSURANCE INFORMATION

Primary Insurance Co: Group #: Policy #:

Name of Insured: SS# Birth Date / / Relationship to Patient:

Secondary Insurance Co: Group #: Policy #:

Name of Insured: SS# Birth Date / / Relationship to Patient:

If you have an HMO insurance plan, did you contact your Primary Care Physician (PCP) for a referral? □ YES □ NO

ACCIDENT/INJURY INFORMATION

Is this due to an accident or injury? □ Yes □ No If yes, date of accident or injury: / /

If yes, please check one of the following: □ Auto Accident □ Liability □ On The Job Injury □ Other (home, etc.)

Is an attorney involved? □ Yes □ No If on the job, did you report this injury to your employer? □ Yes □ No

Was patient seen in the Emergency Room? □ Yes □ No Date: / / Hospital:

Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts on the date of service. By signing this form, I agree to be responsible for any legal fees and/or fees incurred in the collection of charges for this account. I authorize the release of any medical information necessary to process my claim(s). I authorize payment(s) of medical and surgical benefits to **Franklin Orthopaedics & Sports Medicine.**

_____ _____

Responsible Party Today's Date

Patient Name: _____

DOB: ____/____/____ **Acct#:** _____

TOA
TENNESSEE ORTHOPAEDIC ALLIANCE

Patient's Preferences
Regarding their PHI

Telephone Communication Preferences

Location	May we call you here?		May we leave a message?	
Home	❑ Yes	❑ No	❑ Yes	❑ No
Work	❑ Yes	❑ No	❑ Yes	❑ No
Mobile Phone	❑ Yes	❑ No	❑ Yes	❑ No
Other _____	❑ Yes	❑ No	❑ Yes	❑ No

Mail Communication Preferences

May we send mail to your home address? ***(If no, please provide an alternate mailing address below.)*** ❑ Yes ❑ No

_____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

	Name	Telephone
❑ Spouse	_____	_____
❑ Caretaker	_____	_____
❑ Child	_____	_____
❑ Parent	_____	_____
❑ Other	_____	_____

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

❑ Yes
❑ No

Consent to Receive Text Messages

I authorize Tennessee Orthopaedic Alliance (TOA) to contact me by SMS text message for health related notifications and/or appointment reminders. I understand that message/data rates may apply. I know that I am under no obligation to authorize TOA to send text messages. I may opt-out of receiving these communications at any time.

❑ Yes, sign me up for SMS text messages

❑ No thanks, I choose not to participate in SMS text messages

Patient or Personal Representative Signature **Date**

_____ _____

TOA
TENNESSEE ORTHOPAEDIC ALLIANCE

Patient Name_____ Account Number _____

Patient Financial Responsibility

I acknowledge full financial responsibility for services rendered by Tennessee Orthopaedic Alliance. I understand that I am responsible for prompt payment of any amounts due including, but not limited to: co-pays, deductibles, and coinsurance amounts. I understand that payment of co-pays, deductibles and coinsurance amounts are expected at time of service, as well as any prior balances I may owe. I also consent that payment of authorized Medicare and any other insurance benefits may be made on my behalf directly to TOA for any medical and/or therapy, imaging, and/or surgical services furnished. I agree to be responsible for all reasonable attorney fees and collection costs in the event of default of payment of my charges, as outlined in office and financial policy guidelines.

Signed_____Date_____

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I authorize Tennessee Orthopaedic Alliance physicians and staff to render medical treatment and evaluation needed. I further authorize order of x-rays, injections, casting or other diagnostic tests and treatment that may be necessary to diagnose and treat my illness or injuries. I hereby give my consent to TOA to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all protected health information contained in the patient record of:

_____.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice. I also understand that I will not be able to revoke this consent in cases where my provider has referred to it for purposes of disclosing my health information. Written revocation of consent must be sent to the physician's office, Attn: Administration.

Signed_____Date_____

Printed Name _____

Acknowledgment - Notice of Privacy Practices; Waiver of Combined Claims

I hereby acknowledge receipt of TOA's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential protected health information. I have reviewed TOA's Notice of Privacy Practices. I understand that TOA reserves the right to change its privacy practices that are described in that Notice. I also understand that any Revised Notice will be posted on TOAs website, available at each office, or mailed upon request.

Signed_____Date_____

Printed Name _____

If you are not the patient, please specify your relationship to the patient_____

I agree that all disputes or disagreements with TOA regarding any use or disclosure of my "PHI", as described in TOA's Notice of Privacy Policies, will be conducted on an individual basis, and not combined with the dispute of any other person. I expressly waive any right to commence or become a party to any group or class action in any court or other forum.

Signed_____ Date_____

Printed Name _____