

PREMIER
ORTHOPAEDIC SURGERY
Orthopaedic Excellence - Innovative Care

MEDICAL INFORMATION

Date: _____

Patient Name: _____

Height: ___ ft ___ in.

Date of Birth: _____

Weight: _____ lbs.

Pulse: _____

Reason for today's visit: _____

Is this the result of an: INJURY or MVA or N/A

Date of injury/accident: _____

How were you injured? _____

What were the circumstances surrounding the injury/accident:

If not an injury, but an illness, how long has this problem been present? _____

Were you treated by another physician for this problem? YES NO

If YES, please list physician's information:

NAME: _____

ADDRESS: _____

PHONE: _____

Did you make an Emergency Room visit for this problem? YES NO

If YES, which ER: _____

Date of ER visit: _____

Were X-rays taken? YES NO

Are you seeking a second opinion? YES NO

For X-ray purposes, are you pregnant? YES NO

Signature of PATIENT/GUARDIAN _____ DATE: _____

Premier Orthopaedic Surgery, LLC
7360 McGinnis Ferry Road, Suite E
Suwanee, GA 30024
Tel: 678-513-8111 Fax: 678-990-1956

Medical History Questionnaire

Patient's Name: _____ DOB: ____ / ____ / ____

Please indicate who referred you to our practice : _____

List ALL of your Medications (including the dosing)		Medication Allergies
1. _____	6. _____	1. _____
2. _____	7. _____	2. _____
3. _____	8. _____	3. _____
4. _____	9. _____	4. _____
5. _____	10. _____	5. _____

Past Medical History: Please Place A Circle if You or Your Mother or Father have ever had any of the following:

Y= You F=Father M=Mother

Diabetes	Y F M	Psychiatric Problems	Y F M	Heart Disease	Y F M	Thyroid Problems	Y F M
Seizures	Y F M	High Blood Pressure	Y F M	Liver Problems	Y F M	Lung Disease	Y F M
T/B	Y F M	Kidney Disease	Y F M	Kidney Stones	Y F M	Bleeding Disorder	Y F M
Stroke	Y F M	Anesthesia Problems	Y F M	Asthma	Y F M	Type of Cancer	_____
Other: _____							

Past Surgical History :

1. _____
 2. _____
 3. _____
 4. _____
 5. _____

Family History :

1. Mother Age _____ Living / Deceased
 2. Father Age _____ Living / Deceased

Social History :

Martial Status _____ Alcohol use _____
 Tobacco use _____ Quit When? _____

Occupation/Employment :

Employer/School Attending _____ Occupation/Grade _____
 Were you injured at work? _____ Did you notify your employer of your injury? _____ Last date of work? _____

Review of Symptoms: Please circle if you are experiencing any of the following:

Weight gain/loss loss of appetite double vision blurred vision deafness sinusitis vertigo fever shortness of breath
 Wheezing chronic cough abdominal pain constipation diarrhea chest pain palpitations heart murmur
 Painful urination incontinence breast mass breast pain skin rashes change in moles loss of balance loss of memory
 Anxiety depression hallucination sleep disturbances excessive thirst excessive urination heat/cold intolerance
 Anemia bleeding tendencies hives eczema stiffness in joints weakness spine radiating pain to arm/leg

Patient/Guardian Signature _____ Date ____ / ____ / ____



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Orthopaedic Excellence Innovation

Patient Financial Policy

It is the goal of Premier Orthopaedic Surgery to provide the highest quality of medical care to our patients. As a courtesy to our patients we are providing you with this written policy of financial responsibility.

Your insurance coverage is a contract between yourself and the insurance company. It is your responsibility to be sure of proper coverage before being seen by one of our physicians. This includes providing our office with the proper referral if required by your insurance coverage. As a general policy, our office does not file any third party insurances (auto, home owners, or other liability insurance). However, in the case of a motor vehicle accident our office will file auto insurance if provided with the proper documentation to do so. In all other cases we are happy to assist you with obtaining all needed documentation for you to file these yourself and we do expect payment from you when services are rendered.

As a courtesy, we will file these bills with your insurance(s) in a timely fashion, but keep in mind that with most insurance plans there is a portion of fees that are the patient's responsibility. Prompt payment of these fees is expected and appreciated.

While we participate with a host of insurance companies, most plans that we do not participate with do have out of network benefits that allow the patient outside the network coverage at a much reduced rate. In this event, you will be responsible for the difference between what your plan pays and our fee schedule.

While Premier Orthopaedic Surgery understands that some blended family situations are complicated we can not and will not become entangled with various arrangements set forth in Divorce Decrees and the like. Therefore, payment for all services rendered will be expected from the guardian that escorts the patient to their appointments. It is your responsibility to ensure that the appropriate and responsible party is present. Again, payment will be expected from the individual accompanying the patient to the appointment.

If for any reason your insurance coverage changes or other coverage is added, please notify us as soon as possible, to avoid excess cost to you and to make for a smooth transition of coverage.

Charges that are found to be the patient's responsibility will be mailed to you on a detailed statement. These statements are sent out on a routine basis. If no action is taken on your behalf to meet your financial responsibility after sending the third notification, your account will be turned over to the collection agency. In the event that my account is turned over to the collection agency, I understand that I will be responsible for any collection fees, attorneys fees, etc. Any NSF and returned checks will be assessed a \$25.00 charge. I understand that I will be assessed a monthly \$20.00 late fee/re-billing fee. Also, in the event your private insurance has not reimbursed our facility for services rendered after sixty days from the date we file your claim, the patient or the guarantor may be responsible for full payment of the services rendered. If payment is received from the insurance company after you have paid your bill, Premier Orthopaedic Surgery, will refund the payment amount to the appropriate payer.

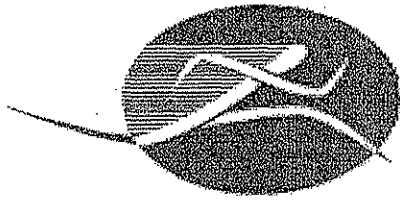
By signing this waiver you authorize the release of all medical information pertinent to your medical care and necessary to the processing of your insurance claims. Also, you authorize the assignment of all medical benefits to Premier Orthopaedic Surgery, LLC.

I have read the above policies in their entirety; I understand and agree to all of them.

PATIENT SIGNATURE: _____ **Date:** _____

GUARDIAN SIGNATURE: _____ **Date:** _____

PRINTED NAME OF PATIENT : _____



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ORTHOPAEDIC SURGERY
Orthopaedic Excellence • Unwavering Care

**Receipt of Notice of Privacy Practices
Written Acknowledgement Form**

I, _____ have been given the opportunity to review a copy of Premier Orthopaedic Surgery, LLC's Notice of Privacy Practices.

SIGNATURE OF PATIENT

DATE

PRINTED NAME OF PATIENT

DATE

SIGNATURE OF GUARDIAN

DATE

For Office Use Only:

We attempted to obtain written acknowledgement from the patient that they have been given the opportunity to review our Notice of Privacy Practices. Acknowledgement could not be obtained because:

- Individual Refused to Sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)