

Patient Name:
Sex:
Age:
Date:



ORTHOMEMPHIS

OrthoMemphis
6286 Briarcrest Avenue, Suite 200
Memphis, Tennessee 38120
(P): 901.259.1600 (F): 901.259.1698

PATIENT INFORMATION SHEET

Name: _____ Middle Initial + Suffix: Mr. Mrs. Miss Ms.

Previous Last Name: _____ Age: _____ DOB: _____ **SSN:** _____

Address: _____ Sex: _____ **Language:** _____

Zip: _____ City: _____ State: _____ **Race:** _____ Declined

Pharmacy: _____ **Phone:** _____ **Ethnicity:** _____ Declined
(PRINT PHARMACY NAME) (PRINT PHARMACY PHONE)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Contact Preference: Home Cell Work Email

Skilled Nursing Facility: Yes No Name: _____ Phone: _____

Employer/School: _____ Full Time Part Time Retired Disabled Student

Employer/School Address: _____ Phone: _____

Patient Status: Married Single Divorced Widow Separated Partner

How did you hear about us? _____ Family Doctor: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Guarantor/Guardian Last Name: _____ First: _____ Middle Initial + Suffix: _____

DOB: _____ Guarantor Address: _____ Zip: _____ City: _____

State: _____ SSN: _____ Phone: _____ Work: _____

Employer: _____ Employer Address: _____

REASON for this visit: LEFT RIGHT **BODY PART:** _____

Type of Injury: **WORK RELATED** Auto Other: _____ Injury Date: _____ State: _____

Where and how were you injured? _____

PRIMARY

SECONDARY

Insurance Company: **(1)** _____ **(2)** _____

Claims Address: _____

City, State, Zip: _____

Phone: _____

ID/Policy #: _____

Group/Plan #: _____

Subscriber's Date of Birth: _____ M F _____ M F

Name of Subscriber: _____

I have been shown a copy of MSK Group, P.C., Privacy Notice and have been provided with a Patient Consent Form for treatment. The financial policy of MSK has been provided to me and I agree to the terms as stated in that policy. I hereby assign to MSK all benefits payable under the terms of my insurance policy listed above. I realize that I am responsible for any balances not payable by my insurance company. I also understand that I will be responsible for any expenses incurred in the collection of outstanding balances that I may have, whether it be from a collection agency or an attorney. I hereby authorize the release and disclosure of my Protected Health Insurance (PHI) for treatment, payment, or health care operations.

Signature of Patient/Guardian: _____ Date: _____

(Must be 18 years old or older to sign)

Patient Name:

DOB:

Age:

Sex:

Date:



ORTHOMEMPHIS

OrthoMemphis

6286 Briarcrest Avenue, Suite 200

Memphis, Tennessee 38120

(P): 901.259.1600 (F): 901.259.1698

CLINICAL HISTORY

Name _____ DOB _____ Age _____ Marital Status S M D W

Occupation _____ Employer _____ Birthplace _____

Education _____ Years High School _____ Years College _____ Years Post Grad **Height:** _____ **Weight:** _____

Date of Last Physical ____ / ____ / ____ Family Doctor _____

List All Medications You are Taking at the Present Time			List All Medications You are Taking at the Present Time		
Medication	Dosage	Taken For	Medication	Dosage	Taken For
1. _____			6. _____		
2. _____			7. _____		
3. _____			8. _____		
4. _____			9. _____		
5. _____			10. _____		

Are you allergic to any medications? Yes No **If yes, please list:** _____

Are you allergic to: Latex Yes No Shellfish Yes No
 Contrast Dye Yes No

How would you rate your general health? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Do you Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, How much? _____	Do you use Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, How much? _____
Have you ever had a drug abuse problem? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever used intravenous drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been exposed to HIV (AIDS virus)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure

NOTE: THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT WHEN YOU HAVE AUTHORIZED US TO DO SO.

MEDICAL HISTORY -- HAVE YOU EVER HAD? Please circle YES or NO for all questions.

CHILDHOOD DISEASES	CARDIAC DISEASES	INFECTIONS
Measles YES NO	Heart Attack YES NO	After Surgery YES NO
Mumps YES NO	Angina YES NO	Venereal Disease YES NO
Chicken Pox YES NO	Heart Murmur YES NO	Hepatitis YES NO
Whooping Cough YES NO	Arrhythmia YES NO	(HIV) AIDS YES NO
Scarlet Fever YES NO	Valve Problems YES NO	Osteomyelitis YES NO
Rheumatic Fever YES NO	Other YES NO	Other YES NO
Other YES NO		
METABOLIC DISEASES	GI DISEASES	BLOOD DISORDERS
Diabetes YES NO	Ulcer YES NO	Anemia YES NO
High Blood Pressure YES NO	Gall Bladder YES NO	Clotting Problems YES NO
Thyroid Disease YES NO	Hiatal Hernia YES NO	Hemophilia YES NO
Osteoporosis YES NO	GI Bleed YES NO	Other YES NO
Other YES NO	Obstruction YES NO	
	Other YES NO	
PULMONARY DISEASES	UROLOGIC DISEASES	ARTHRITIS
Pneumonia YES NO	Urinary Tract Infection YES NO	Rheumatoid YES NO
Asthma YES NO	Kidney Stone YES NO	Osteoarthritis YES NO
Copd? YES NO	Dialysis YES NO	Gout YES NO
Tuberculosis YES NO	Other YES NO	Other YES NO
Other YES NO		
CNS DISEASE	CANCER	MISCELLANEOUS
Stroke YES NO	If yes, location _____	Blood Clots YES NO
Seizure YES NO	Year Diagnosed _____	Thrombophlebitis YES NO
Other _____ YES NO	Reoccurrence YES NO	Sleep Apnea YES NO
	Current Treatment YES NO	Any other disease YES NO
		List: _____

		Prior Blood Transfusion _____
		If yes, year _____

PATIENT INITIALS AND DATE	PATIENT INITIALS AND DATE	FOR OFFICE USE ONLY
DATE _____ INITIALED _____	DATE _____ INITIALED _____	DATE _____ INITIALED _____
_____	_____	_____
_____	_____	_____

Signature of Patient/Guardian: _____ Date: _____

Patient Name:

DOB:

Age:

Sex:

Date:



ORTHOMEMPHIS

OrthoMemphis

6286 Briarcrest Avenue, Suite 200

Memphis, Tennessee 38120

(P): 901.259.1600 (F): 901.259.1698

CLINICAL HISTORY

Date:

SURGICAL HISTORY

Have you had previous surgery? YES NO. If yes, what type? Year Type Year. 1. 2. 3. 4. 5. 6.

HOSPITALIZATIONS

Have you ever been hospitalized for any illness other than surgery or childbirth? YES NO. If yes, please list Diagnosis Year Diagnosis Year. 1. 2. 3. 4.

List Physicians seen in the last 5 years (most recent first)

List Physicians seen in the last 5 years (most recent first)

Name Seen for. Name Seen for.

REVIEW OF SYSTEMS -- ARE YOU NOW HAVING? Please check YES or NO for all questions.

MUSCULOSKELETAL/INJURIES, HEENT, RESPIRATORY, NEUROLOGICAL, GASTROENTEROLOGICAL, IMMUNOLOGICAL/LYMPHATIC, CARDIOLOGICAL, GENITOURINARY, CONSTITUTIONAL, PSYCHIATRIC.

OB/GYN (Women Only)

Is there any chance you could be pregnant? YES NO NOT SURE. Taking Estrogen? YES NO. Any history of abnormal menstrual cycle? YES NO. Menopause? YES NO If Yes, Year

FAMILY HISTORY--Has any blood relative ever had:

Heart problems, Diabetes, High Blood Pressure, Stroke, Epilepsy, Tuberculosis, Cancer. WHO: _____

PATIENT INITIALS AND DATE. DATE INITIALED

PATIENT INITIALS AND DATE. DATE INITIALED

FOR OFFICE USE ONLY. DATE INITIALED

Signature of Patient/Guardian: _____ Date: _____

Patient Name:
DOB:
Age:
Sex:
Date:



ORTHOMEMPHIS

OrthoMemphis
6286 Briarcrest Avenue, Suite 200
Memphis, Tennessee 38120
(P): 901.259.1600 (F): 901.259.1698

NOTICE OF FINANCIAL RELATIONSHIP / INTEREST

OrthoMemphis

A division of MSK Group, P.C.

This is to advise you that certain physicians of OrthoMemphis, a division of MSK Group, P.C. have a financial interest in the OrthoMemphis Physical Therapy Center, OrthoMemphis MRI Center and other area ambulatory/outpatient surgery centers.

With regard to physical therapy services, a physician of OrthoMemphis may refer _____
to the OrthoMemphis Physical Therapy Center. This center is owned by the physicians of OrthoMemphis.

T.C.A. §63-6-602© requires a physician who refers a patient for physical therapy to provide certain notices if the physician has a financial relationship with that physical therapy practice.

This document serves as an additional notice of the following:

- * Your OrthoMemphis physician may have a financial interest in the physical therapy practice he is referring you to;
- * You have a right to receive physical therapy services at any physical therapy practice of your choice;
- * You have the option to use an alternative physical therapy practice;
- * You will not be treated any differently by this practice or by your physician if you choose not to use the OrthoMemphis Physical Therapy Center.

Patient / Parent / Legal Representative **Initial:** _____ **Date:** _____

Patient Name:
DOB:
Age: Sex:
Date:



ORTHOMEMPHIS

OrthoMemphis
6286 Briarcrest Avenue, Suite 200
Memphis, Tennessee 38120
(P): 901.259.1600 (F): 901.259.1698

MSK GROUP, PC

We appreciate the opportunity to serve you and desire to provide you with the best service possible. The information below is intended to ensure you are aware of certain treatment, financial, and privacy policies. If you have any questions, please inform a member of our front-desk staff.

Consent for Medical Treatment

I authorize the physicians of MSK Group, PC (MSK) and their health care team to render the evaluation and medical treatment needed. I further authorize the use of x-rays, injections, casting, bracing, or other diagnostic tests and treatment as determined necessary by my health care provider.

Consent for Electronic Prescribing

I authorize the physicians, and other appropriate licensed providers of MSK and their healthcare team to submit my prescriptions to my pharmacy using secure e-prescribing software. I further authorize access to my medical history, prescription history, and current medications from any and all health care providers.

Consent for Student Participation

I understand that my attending physician and/or other MSK personnel may be accompanied and/or assisted by students in various fields of study related to healthcare, such as nursing, physician assistant, physical therapy, medical students, interns, residents, and other allied health fields, and at various stages in their education. I consent to the presence/and or participation in my treatment by these persons while under the direction or supervision of my physician or other healthcare provider.

Acknowledgement of Receipt of Privacy Practices Notice

I hereby acknowledge I have been offered and/or received a copy of the Privacy Practices Notice of MSK. The Group and its representatives may contact me and leave a voicemail message if necessary unless I completed a *Restriction Form* which has been approved in writing by MSK.

Consent for Financial Responsibility

I acknowledge full financial responsibility for services rendered by MSK. I assign and authorize payments of medical insurance benefits to MSK directly, and release of any medical information necessary to process insurance claims. Additionally, I understand that I am responsible for expenses that may be incurred in collecting this account to include attorney's fees, court costs, and collection agency costs in the event of default of payment of my charges. It is my responsibility to contact my insurance company and/or employer to verify that MSK and its licensed medical providers are participants in my insurance plan prior to treatment at MSK. MSK does not accept third party liability, such as automobile insurance, pending litigation, and other indirect insurance products, and I am responsible for the full payment of services at the time rendered.

If my insurance plan requires a referral in order to be treated by an MSK provider, it is my responsibility to obtain the referral prior to being treated at MSK. If a referral is required and I fail to obtain one, I will be financially responsible for any services rendered.

MSK will submit a claim to my insurance company but will require payment of any unpaid deductible, copayments and coinsurance for services provided in the office at the time rendered. If I am without verified health insurance or with a plan MSK does not participate, I am required to pay in full at the time services are rendered. In the event my insurance company denies my claim or pays my claim as "out-of-network," I am responsible for the balance.

Some insurance companies may determine that certain orthopaedic supplies that healthcare professionals prescribe for the patient's well being are not covered. I agree to pay for these supplies in the event my insurance company denies coverage.

MSK accepts cash, check, bank debit card, MasterCard, Visa, or Discover. Each instance of a returned check is subject to a \$15 processing fee.

Signature of Patient/Guardian: _____ Date: _____
(Must be 18 years old or older to sign)

In the event we cannot contact you, please list family members or other persons, if any, who we may inform about your general medical condition and diagnosis.

NAME: _____ **RELATIONSHIP:** _____ **PHONE:** _____

Patient Name:

DOB:

Age:

Sex:

Date:



ORTHOMEMPHIS

OrthoMemphis

6286 Briarcrest Avenue, Suite 200

Memphis, Tennessee 38120

(P): 901.259.1600 (F): 901.259.1698

PHARMACY INFORMATION

PHARMACY NAME

Pharmacy Name: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone Number: _____