

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 _____

Table with 2 columns: 'List All Medications You are Taking at the Present Time' (Medication, Dosage, Taken For) and 'List All Medications You are Taking at the Present Time' (Medication, Dosage, Taken For). Rows 1-5 and 6-10.

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? Good Fair Poor Do you Smoke? Yes No Do you use Alcohol? Yes No If Yes, How much? Have you ever had a drug abuse problem? Yes No Have you ever used intravenous drugs? Yes No Have you ever been exposed to HIV (AIDS virus)? Yes No 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.

Table with 3 columns: CHILDHOOD DISEASES, METABOLIC DISEASES, PULMONARY DISEASES, CNS DISEASE, CARDIAC DISEASES, GI DISEASES, UROLOGIC DISEASES, CANCER, INFECTIONS, BLOOD DISORDERS, ARTHRITIS, MISCELLANEOUS. Each cell contains a disease name and YES/NO options.

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

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 YES NO WHO: Diabetes YES NO WHO: High Blood Pressure YES NO WHO: Stroke YES NO WHO: Epilepsy YES NO WHO: Tuberculosis YES NO WHO: Cancer YES NO 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:
Date:

Sex:



ORTHOMEMPHIS

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

SPINE HISTORY

1. My main problem is:

Neck Pain Left Arm Upper Back Left Leg Other: _____
Scoliosis Right Arm Lower Back Right Leg _____

2. Please describe the distribution of your pain.

Back _____ % + Leg _____ % = 100
Neck _____ % + Arm _____ % = 100

3. Date of injury or onset of symptoms: _____

4. Was there an injury? Yes No

5. Are your symptoms work related? Yes No

6. If work related, how are your symptoms related: _____

7. Quality of pain? Aching Burning Sharp Dull Throbbing Shooting Stiffness
(Check all that apply)

8. Since the onset of symptoms, your pain has: Increased Decreased Remained the same

9. What activities make the pain worse? (Check all that apply)

a. During Exercise e. Walking i. Sneezing
b. After Exercise f. Bending forward j. Housework
c. Sitting g. Bending backward k. Sexual activities
d. Standing h. Coughing

10. What activities reduce your pain? (Check all that apply)

a. Lying down e. Manipulation i. Aspirin
b. Sitting f. Physical Therapy j. Other _____
c. Standing g. Pain pills k. Nothing
d. Walking h. Muscle relaxers

11. Do you feel stiffness in the morning? Yes No

I feel best in the: Morning Afternoon Evening Night

I feel worst in the: Morning Afternoon Evening Night

11. Do you have numbness in your:

Right Arm Where: _____ Right Leg Where: _____
Left Arm Where: _____ Left Leg Where: _____

12. Do you have weakness in your:

Right Arm Where: _____ Right Leg Where: _____
Left Arm Where: _____ Left Leg Where: _____

13. Is your bowel and bladder normal? Yes No

14. How many hours do you sleep at night? _____ Does the pain awaken you from sleep at night? Yes No

15. Are you on Workers' Compensation? Yes No 16. Are you working now? Yes No

17. Do you receive disability income? Yes No

18. Do you have legal representation for this medical problem? Yes No

Are legal proceedings pending? Yes No

19. What doctors have you seen regarding this problem? _____

20. Which of the following diagnostic studies have been performed?

Exam	Yes	No	Date	Location / Hospital
X-Rays	<input type="checkbox"/>	<input type="checkbox"/>		
CT Scans	<input type="checkbox"/>	<input type="checkbox"/>		
Myelogram	<input type="checkbox"/>	<input type="checkbox"/>		
EMG	<input type="checkbox"/>	<input type="checkbox"/>		
MRI	<input type="checkbox"/>	<input type="checkbox"/>		
Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>		
Discogram	<input type="checkbox"/>	<input type="checkbox"/>		

21. Which of the following treatments have you received?

Type	Yes	No	How Many?	Effect (Check appropriate response)		
Hotpacks	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Ice	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Whirlpool	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Electrical Stimulation	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Massage	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Manipulation	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Exercise Program	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Pain Management Program	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response

22. Medications

Type of Medication	Yes	No	How Many?	Effect (Check appropriate response)		
Anti-Inflammatory	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Motrin/Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Naprosyn/Aleve	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Celebrex	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Mobic	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Voltaren	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Muscle Relaxants	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Soma	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Flexeril	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Skelaxin	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Pain Medications	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Darvocet	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Percocet	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
Lortab	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response

23. Injections

Type of Medication	Yes	No	How Many / Location	Effect (Check appropriate response)		
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response

24. Surgery

Type / Level	Date	Hospital / City	Surgeon	Effect (Check appropriate response)		
				<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response
				<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Response

Patient Name: Lname, Fname

DOB: /DOB

Age: /Age

Sex: /Sex

Date: 2/21/2013



OrthoMemphis

6286 Briarcrest Avenue, Suite 200

Memphis, Tennessee 38120

(P): 901.259.1600 (F): 901.259.1698

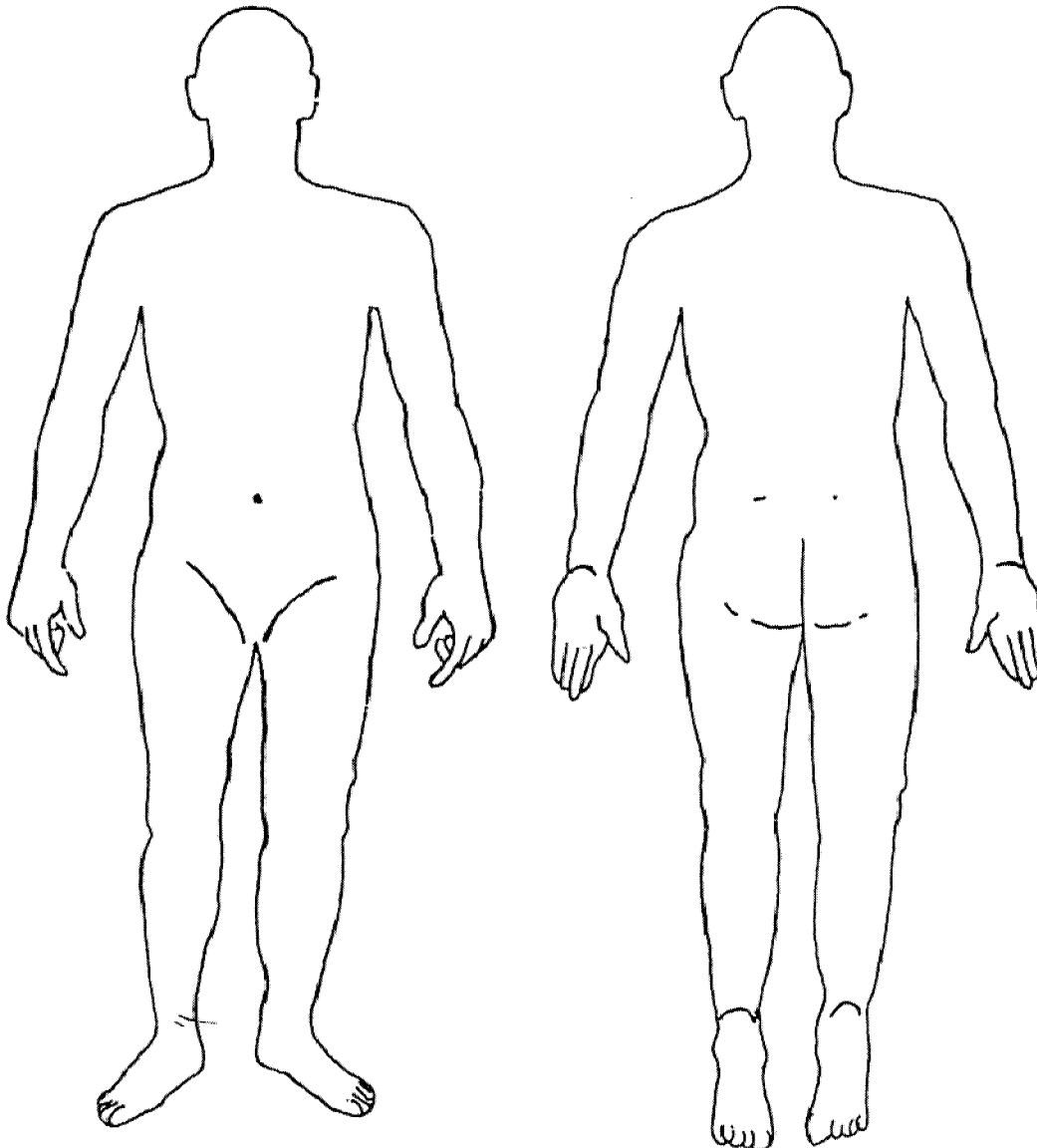
ORTHOMEMPHIS

SPINE HISTORY

THE ORTHOPAEDIC DIAGRAM

MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. USE THE APPROPRIATE SYMBOL. MARK AREAS OF RADIATION. INCLUDE ALL AFFECTED AREAS.

NUMBNESS/TINGLING	-----	ACHING	0	STIFFNESS	▲▲▲▲
	-----		0		
BURNING	x x x	STABBING	///	DULL	>>>
	x x x		///		>>>



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

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

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

PHARMACY INFORMATION

PHARMACY NAME

Pharmacy Name: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone Number: _____