Patient Name:
DOB:
Age:
Sex:
Date:

ORTHOMEMPHIS

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

PATIENT INFORMATION SHEET - WORKERS' COMPENSATION

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

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

Address: _____ Sex: _____

Zip: _____ City: _____ State: _____

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

Language: _____

Race: _____ ☐ Declined

Ethnicity: _____ ☐ Declined

Home Phone: _____ **W**ork Phone: _____ **C**ell Phone: _____

Email Address: _____ Contact Preference: ☐ Home ☐ Cell ☐ Work ☐ Email

Employer: _____ ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled ☐ Student

Employer Address: _____ Phone: _____

Patient Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Separated ☐ Partner

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

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Spouse's Last Name: _____ First: _____ Middle Initial + Suffix: _____

DOB: _____ Spouse's Address: _____ Zip: _____ City: _____

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

Cell: _____ Employer: _____ Employer Address: _____

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

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

Where and how were you injured? _____

W/C INSURANCE COMPANY	**EMPLOYER**	**CASE MANAGER**
Name:		
Address:		
City, State, Zip:		
Phone:		
Attn:		
Fax:		
Claim #:		

Authorized By: _____ Date: _____

I ACCEPT PERSONAL RESPONSIBILITY FOR PAYMENT OF CHARGES FOR SERVICES RENDERED TO ME. I AUTHORIZE PAYMENTS OF MEDICAL INSURANCE BENEFITS TO ORTHOMEMPHIS. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS. I HAVE RECEIVED A COPY OF THE PRIVACY ACT.

Date: _____ Signature of Patient or Guardian: _____

Patient Name:
DOB:
Age:
Sex:
Date:

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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? ☐ Good ☐ Fair ☐ Poor	Do you Smoke? ☐ Yes ☐ No **If Yes, How much?**	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.

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	**GI DISEASES**			**BLOOD DISORDERS**		
METABOLIC DISEASES			Ulcer	YES	NO	Anemia	YES	NO
Diabetes	YES	NO	Gall Bladder	YES	NO	Clotting Problems	YES	NO
High Blood Pressure	YES	NO	Hiatal Hernia	YES	NO	Hemophilia	YES	NO
Thyroid Disease	YES	NO	GI Bleed	YES	NO	Other	YES	NO
Osteoporosis	YES	NO	Obstruction	YES	NO	**ARTHRITIS**		
Other	YES	NO	Other	YES	NO	Rheumatoid	YES	NO
PULMONARY DISEASES			**UROLOGIC DISEASES**			Osteoarthritis	YES	NO
Pneumonia	YES	NO	Urinary Tract Infection	YES	NO	Gout	YES	NO
Asthma	YES	NO	Kidney Stone	YES	NO	Other	YES	NO
Copd?	YES	NO	Dialysis	YES	NO	**MISCELLANEOUS**		
Tuberculosis	YES	NO	Other	YES	NO	Blood Clots	YES	NO
Other	YES	NO	**CANCER**	YES	NO	Thromophlebitis	YES	NO
CNS DISEASE			If yes, location			Sleep Apnea	YES	NO
Stroke	YES	NO	Year Diagnosed			Any other disease	YES	NO
Seizure	YES	NO	Reoccurence	YES	NO	List:		
Other _____	YES	NO	Current Treatment	YES	NO			
						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:

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CLINICAL HISTORY

Date:

SURGICAL HISTORY

Have you had previous surgery? ☐ YES ☐ NO

If yes, what type?	Year	Type	Year
1.		4.	
2.		5.	
3.		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.		3.	
2.		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		
Fracture/Broken Bone	☐ YES	☐ NO	Impaired Sight	☐ YES	☐ NO	Cough	☐ YES	☐ NO	Weakness	☐ YES	☐ NO
Body Part _____	☐ YES	☐ NO	Headaches	☐ YES	☐ NO	Shortness of Breath	☐ YES	☐ NO	Paralysis	☐ YES	☐ NO
Joint Pain	☐ YES	☐ NO	**SKIN**			Wheezing	☐ YES	☐ NO	Numbness/	☐ YES	☐ NO
Body Part _____	☐ YES	☐ NO	Frequent Rashes	☐ YES	☐ NO	**GASTROENTEROLOGICAL**			Altered Sensation		
Joint Swelling	☐ YES	☐ NO	Skin Irritation	☐ YES	☐ NO	Spitting up Blood	☐ YES	☐ NO	**PSYCHIATRIC**		
Body Part _____	☐ YES	☐ NO	Bruising	☐ YES	☐ NO	Constipation	☐ YES	☐ NO	Depression	☐ YES	☐ NO
Back Pain	☐ YES	☐ NO	**IMMUNOLOGICAL/LYMPHATIC**			Diarrhea	☐ YES	☐ NO	Schizophrenia	☐ YES	☐ NO
Neck Pain	☐ YES	☐ NO	Frequent Infections	☐ YES	☐ NO	Heartburn	☐ YES	☐ NO	Bipolar Disorder	☐ YES	☐ NO
CONSTITUTIONAL			Swelling of Feet	☐ YES	☐ NO	Rectal Bleeding	☐ YES	☐ NO		☐ YES	☐ NO
Night Sweats	☐ YES	☐ NO	**CARDIOLOGICAL**			Black Stools	☐ YES	☐ NO	Drug or Alcohol Abuse		
Abnormal Thirst	☐ YES	☐ NO	Dizziness	☐ YES	☐ NO	Loss of Bowel Control	☐ YES	☐ NO			
Weight Loss	☐ YES	☐ NO	Fainting	☐ YES	☐ NO	**GENITOURINARY**					
Fevers or Chillls	☐ YES	☐ NO	Chest Pain	☐ YES	☐ NO	Frequent Urination	☐ YES	☐ NO			
			Palpitations/Irreg. Heartbeat	☐ YES	☐ NO	Painful Urination	☐ YES	☐ NO			
						Loss of Urine Control	☐ YES	☐ NO			

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

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

Signature of Patient/Guardian: _____ **Date:** _____

FORM C-31

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

Division of Workers' Compensation

MEDICAL WAIVER AND CONSENT

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE DIVISION OF WORKERS' COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. § 50-6-204 AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

I,_____, having filed a claim for worker's compensation benefits, do hereby authorize

MSK GROUP, PC

(Name of Medical Provider)

to furnish to my employer or my employer's representative, and/or the Division of Workers' Compensation any information or written material reasonably related to my work-related injury for which I am claiming compensation.

I further authorize the release of the same information to me or my attorney.

The authorization includes, but is not restricted to, a right to review and obtain copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

A photocopy of the authorization may be accepted in lieu of the original.

Dated:_____, 20___.

_____ _____

Patient (Legal Guardian if under 18) Social Security last four numbers

_____

Witness

Patient Name:
DOB:
Age: Sex:
Date:

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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:

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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:

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PHARMACY INFORMATION

PHARMACY NAME

Pharmacy Name:_____

Address:_____

City: _____

State: _____

Zip: _____

Phone Number:_____