



# ORTHOMEMPHIS

## 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)

|   |
|---|
| <b>Language:</b> _____                                    |
| <b>Race:</b> _____ <input type="checkbox"/> Declined      |
| <b>Ethnicity:</b> _____ <input type="checkbox"/> Declined |

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell 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? \_\_\_\_\_

| <b>W/C INSURANCE COMPANY</b> | <b>EMPLOYER</b> | <b>CASE MANAGER</b> |
|------------------------------|-----------------|---------------------|
|------------------------------|-----------------|---------------------|

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: \_\_\_\_\_



# ORTHOMEMPHIS

## 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               |                                |                               |
| 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 _____            |

|                                  |                                  |                            |
|----------------------------------|----------------------------------|----------------------------|
| <b>PATIENT INITIALS AND DATE</b> | <b>PATIENT INITIALS AND DATE</b> | <b>FOR OFFICE USE ONLY</b> |
| DATE _____ INITIALED _____       | DATE _____ INITIALED _____       | DATE _____ INITIALED _____ |
| _____                            | _____                            | _____                      |
| _____                            | _____                            | _____                      |

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



# ORTHOMEMPHIS

## 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 <input type="checkbox"/> YES <input type="checkbox"/> NO | Impaired Sight <input type="checkbox"/> YES <input type="checkbox"/> NO                | Cough <input type="checkbox"/> YES <input type="checkbox"/> NO                 | Weakness <input type="checkbox"/> YES <input type="checkbox"/> NO         |
| Body Part _____ <input type="checkbox"/> YES <input type="checkbox"/> NO      | Headaches <input type="checkbox"/> YES <input type="checkbox"/> NO                     | Shortness of Breath <input type="checkbox"/> YES <input type="checkbox"/> NO   | Paralysis <input type="checkbox"/> YES <input type="checkbox"/> NO        |
| Joint Pain <input type="checkbox"/> YES <input type="checkbox"/> NO           | <b>SKIN</b>  | Wheezing <input type="checkbox"/> YES <input type="checkbox"/> NO              | Numbness/ <input type="checkbox"/> YES <input type="checkbox"/> NO        |
| Body Part _____ <input type="checkbox"/> YES <input type="checkbox"/> NO      | Frequent Rashes <input type="checkbox"/> YES <input type="checkbox"/> NO               | <b>GASTROENTEROLOGICAL</b>   | Altered Sensation   |
| Joint Swelling <input type="checkbox"/> YES <input type="checkbox"/> NO       | Skin Irritation <input type="checkbox"/> YES <input type="checkbox"/> NO               | Spitting up Blood <input type="checkbox"/> YES <input type="checkbox"/> NO     | <b>PSYCHIATRIC</b>  |
| Body Part _____ <input type="checkbox"/> YES <input type="checkbox"/> NO      | Bruising <input type="checkbox"/> YES <input type="checkbox"/> NO                      | Constipation <input type="checkbox"/> YES <input type="checkbox"/> NO          | Depression <input type="checkbox"/> YES <input type="checkbox"/> NO       |
| Back Pain <input type="checkbox"/> YES <input type="checkbox"/> NO            | <b>IMMUNOLOGICAL/LYMPHATIC</b>   | Diarrhea <input type="checkbox"/> YES <input type="checkbox"/> NO              | Schizophrenia <input type="checkbox"/> YES <input type="checkbox"/> NO    |
| Neck Pain <input type="checkbox"/> YES <input type="checkbox"/> NO            | Frequent Infections <input type="checkbox"/> YES <input type="checkbox"/> NO           | Heartburn <input type="checkbox"/> YES <input type="checkbox"/> NO             | Bipolar Disorder <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <b>CONSTITUTIONAL</b>   | Swelling of Feet <input type="checkbox"/> YES <input type="checkbox"/> NO              | Rectal Bleeding <input type="checkbox"/> YES <input type="checkbox"/> NO       | <input type="checkbox"/> YES <input type="checkbox"/> NO                  |
| Night Sweats <input type="checkbox"/> YES <input type="checkbox"/> NO         | <b>CARDIOLOGICAL</b>   | Black Stools <input type="checkbox"/> YES <input type="checkbox"/> NO          | Drug or Alcohol Abuse   |
| Abnormal Thirst <input type="checkbox"/> YES <input type="checkbox"/> NO      | Dizziness <input type="checkbox"/> YES <input type="checkbox"/> NO                     | Loss of Bowel Control <input type="checkbox"/> YES <input type="checkbox"/> NO |   |
| Weight Loss <input type="checkbox"/> YES <input type="checkbox"/> NO          | Fainting <input type="checkbox"/> YES <input type="checkbox"/> NO                      | <b>GENITOURINARY</b>   |   |
| Fevers or Chills <input type="checkbox"/> YES <input type="checkbox"/> NO     | Chest Pain <input type="checkbox"/> YES <input type="checkbox"/> NO                    | Frequent Urination <input type="checkbox"/> YES <input type="checkbox"/> NO    |   |
|   | Palpitations/Irreg. Heartbeat <input type="checkbox"/> YES <input type="checkbox"/> NO | Painful Urination <input type="checkbox"/> YES <input type="checkbox"/> NO     |   |
|   |  | Loss of Urine Control <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> YES <input type="checkbox"/> NO WHO: _____      | Stroke <input type="checkbox"/> YES <input type="checkbox"/> NO WHO: _____       |
| Diabetes <input type="checkbox"/> YES <input type="checkbox"/> NO WHO: _____            | Epilepsy <input type="checkbox"/> YES <input type="checkbox"/> NO WHO: _____     |
| High Blood Pressure <input type="checkbox"/> YES <input type="checkbox"/> NO WHO: _____ | Tuberculosis <input type="checkbox"/> YES <input type="checkbox"/> NO WHO: _____ |
|   | Cancer <input type="checkbox"/> YES <input type="checkbox"/> 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: \_\_\_\_\_



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



# ORTHOMEMPHIS

## 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:** \_\_\_\_\_



# ORTHOMEMPHIS

## PHARMACY INFORMATION

### PHARMACY NAME

Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_