**NI FU INJ FX AC DOCTOR_____ ACCT#_____**

## The Central Orthopedic Group, LLP PLV / RVC / MASS

**DATE** _____

**Patient Last name_____First_____**DOB_____Age _____

Parent or Guardian (if under 18)_____ Contact Phone # _____

**Address _____City _____State _____Zip Code _____**

Home Phone # _____ Work # _____ Cell #_____

S.S. #_____ Male____ Female____ Employer_____ **Email:_____**

Referring Physician _____ Address _____

Telephone #_____ Fax #_____

Primary care physician_____

Address _____Telephone # _____ Fax #_____

**Pharmacy Name** _____**Telephone #** _____ **Address** _____

**BODY PART_____ RIGHT / LEFT (*CIRCLE*)**

**Date of Injury_____ Duration of Problem** _____

**Seen in Emergency room? YES OR NO (*CIRCLE*) Date_____ Name of Facility_____**

**X-Rays Taken ? YES OR NO Date** _____ **Facility** _____

**MRI/ CT SCAN Taken? YES OR NO Date** _____ **Facility** _____

**CURRENT MEDICATIONS:**

_____

_____

_____

_____

_____

**MEDICAL CONDITIONS:**

_____

_____

_____

_____

_____

**OFFICE USE ONLY!**

____ YES ____ NO HAVE YOU BEEN DIAGNOSED WITH ANY ALLERGIES NOT LISTED IN YOUR PREVIOUS HISTORY? PLEASE LIST: _____

**OVER ➔**

**IS THIS WORK OR CAR RELATED? YES OR NO SIGN_____ DATE _____**

**PRIVATE INSURANCE INFORMATION:**

Name of Insurance Company _____ Policy #_____

Name of Policy Holder _____ Relationship to Patient _____

DOB of Policy Holder _____ S.S. # of Policy Holder _____

**SECONDARY INSURANCE INFORMATION**:

Name of Insurance Company _____ Policy #_____

Name of Policy Holder _____ Relationship to Patient _____

DOB of Policy Holder _____ S.S. # of Policy Holder _____

____ YES ____ NO DO YOU HAVE ADDITIONAL DIFFICULTY OR ARE YOU EXPERIENCING SYMPTOMS RELATED TO THIS CONDITION SINCE YOUR LAST VISIT? PLEASE DESCRIBE: _____

_____

____ YES ____ NO ARE YOU PREGNANT OR IS THERE ANY CHANCE OF YOU BEING PREGNANT?

_____

____ YES ____ NO ANY SURGERIES SINCE YOUR LAST VISIT? _____

_____

## MEDICAL INFORMATION RELEASE

I authorize the release of any medical information necessary to process an insurance claim and authorize direct payment to : The Central Orthopedic Group, LLP. I understand that I am financially responsible for treatment rendered.

_____

Signature of Patient or Authorized Representative: Date

## GUARANTEE AGREEMENT

INDIVIDUAL'S RESPONSIBILITY FOR NON-COVERED SERVICES

In the event that I fail to provide the Central Orthopedic Group, LLP with valid insurance information or if it is determined by the insurance Carrier that the condition is not as state above, I agree to pay for all medical services rendered to me by the Central Orthopedic Group, LLP.

_____

Signature of Patient or Authorized Representative: Date

PHYSICIAN SIGNATURE:_____

Date _____

VITALS TO BE COMPLETED BY MA

BMI _____

TEMP _____

HEIGHT _____

WEIGHT _____

**MA INITIAL _____**

**OVER ➔**