



Patient Name Last First MI Maiden Marital Status: M S D W (Circle One)

Social Security #: Date of Birth: Age: Sex: M F

Address: Street City State Zip

E-mail Address: Race: Ethnicity: Preferred Language:

Phone Home: () # Work: () # Cell: () #

NOTE: Please designate the phone number that is best to reach you for reminder/reschedule/call back (ex: #1-best number, #2-next best number etc.)

IF WE ARE UNABLE TO REACH YOU, WHO MAY WE RELEASE MEDICAL AND/OR BILLING INFORMATION TO? (Emergency Notification and Contacts)
(Exception: X-Ray, Path and/or Lab results will be given only to the patient or "designee". Results will not be left on an answering machine.)

Name Relationship Phone #

Name Relationship Phone #

Referring Doctor: Name City State Family Doctor: Name City State

Reason for exam:

How did incident occur?

Body Part: Left Right Both

Date of Injury? Gradual Onset

Have you been treated for the injury prior to your appointment today? Yes No

If yes, date you were first treated? Where? Who treated you?

Were X-Rays Bone Scan CT Scan MRI EMG/NCV taken? (Circle all that apply)

Location these were taken:

Employment Information

Company Name:

Address: City State Zip

Occupation:

If this is an injury, is the injury related to an on the job accident? Yes No

If Yes: a) Have you reported the accident to your employer? Yes No

b) Were you referred by a Work Comp Doctor? Yes No

If No: a) Was this injury a result of a car accident? Yes No

b) Did the injury occur on another person's property? Yes No

Do you have an attorney representing you in a claim regarding the above injury?

Attorney: Name Address City State Zip

INSURANCE INFORMATION (copy of insurance card is needed)

Insurance Name: Primary Policy Holder: Name Date of Birth SS# of Policy Holder

Insurance Name: Secondary Policy Holder: Name Date of Birth SS# of Policy Holder

If patient is a minor, please print name of parent or guardian responsible for bill: (must be present)

Guardian Name:

Address: Street City State Zip

Date of Birth MM/DD/YY Soc Sec # - -

Review of Systems



MILLER
ORTHOPEDIC
SPECIALISTS

Patient Name _____

Date _____

Please mark ALL

General (Constitutional)

Yes No

- Weight Loss
 Weight Gain
 Fever
 Trouble Sleeping
 Difficulty with daily activity (if yes, please explain)
-
-

Eyes/Ears/Nose/Throat (HEENT)

Yes No

- Headaches
 Ringing in Ears
 Vertigo/Dizziness

Respiratory

Yes No

- Cough
 Shortness of Breath

Cardiovascular

Yes No

- Edema (swelling of ankles)
 Chest Pain
 Dyspnea on Exertion(shortness of breath)

Intestinal (Gastrointestinal)

Yes No

- Heartburn
 Upset stomach due to medication
 Change in bowel/bladder habits

Urinary (Genitourinary)

Yes No

- Frequent Urination
 Burning

Neurological

Yes No

- Numbness
 Tingling

Psychological (Psychiatric)

Yes No

- Depression
 Nervousness

Skin (Integumentary)

Yes No

- Rashes
 Open Sore

Musculoskeletal

Yes No

- Stiffness
 Joint Swelling
 Muscle Weakness
 Back Pain

Lymph/Hematology (Hematologic)

Yes No

- Bleeding Tendency
 Anemia
 Bruise Easily

Reviewed By _____

Date _____



AUTHORIZATION FOR CONSENT TO TREATMENT

I consent to treatment and to the use or disclosure of my protected health information by Miller Orthopedic Specialists for the purpose of diagnosing or providing treatment to me and obtaining payment for my health care operations of Miller Orthopedic Specialists as may be deemed necessary or desirable by my attending physician, their assistants and designees. This authorization includes, but is not limited to, evaluation, routine diagnostic procedures, laboratory tests and operative procedures.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of the examination and treatment in this facility. I acknowledge that my care is under the direction of my attending physician, and the facility will follow the instructions of my physician in the provision of said care.

I hereby authorize Miller Orthopedic Specialists to release any medical information and/or to leave messages regarding my appointments to my contacts listed on the patient information form.

I hereby authorize Miller Orthopedic Specialists to release any medical information to my referring and/or family doctor and any information to insurance that is necessary to process and consider health insurance claims, *including workers' compensation carriers and/or employers*. I hereby assign my insurance benefits to be paid directly to Miller Orthopedic Specialists Physicians or Physician Assistants for service rendered for which Miller Orthopedic Specialists participates. I also accept responsibility for all charges provided by Miller Orthopedic Specialists Physicians or Physician Assistants not covered by this assignment for lack of referral or prior workers' compensation authorization.

I hereby proclaim that the above information is accurate and complete.

Patients, Parent/Legal guardian or Power of Attorney signature:

X _____ Date: _____

Print Name: _____