MILLER ORTHOPEDIC SPECIALISTS

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Patient Name _____ Marital Status: M S D W
Last First MI Maiden (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: _____ Family Doctor: _____
Name City State 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: _____ Policy Holder: _____ _____-_____-_____
Primary Name Date of Birth SS# of Policy Holder

Insurance Name: _____ Policy Holder: _____ _____-_____-_____
Secondary 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_____ Soc Sec # _____-_____-_____
MM/DD/YY

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Review of Systems

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_____

MILLER
ORTHOPEDIC
SPECIALISTS

1 Edmundson Place, Suite 500
Council Bluffs, IA 51503
712-323-5333

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: _____