M&M ORTHOPAEDICS

Extraordinary Outcomes

I. CONSENT FOR DIAGNOSIS AND TREATMENT

I am visiting M&M Orthopaedics, Ltd. voluntarily for the purpose of diagnosis and medical or surgical treatment. I consent to consultation by my physician, physician assistant or therapist, and x-rays as deemed necessary. 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 the result of treatment or examination while visiting M&M Orthopaedics.

II. ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You may review our notice, which is displayed in the Waiting Room, posted on our website (www.mmortho.com) and available from our Front Desk staff. As provided in our notice, the terms of this notice may change. If we change our notice, you may obtain a revised copy from our Front Desk staff.

May we speak to someone other than yourself regarding your treatment?

NAME ______________________________ RELATIONSHIP ____________________

III. ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

In consideration of medical services provided to me by M&M Orthopaedics, Ltd., I hereby assign M&M Orthopaedics, Ltd., its physicians and other professionals associated with the practice all of my rights and claims for reimbursement under any Medicare/Medicaid or group accident or health insurance policy for which benefits may be available for payment of the services provided. I agree to pay M&M Orthopaedics and the physician and other professionals associated with the Practice the balance due of all charges not paid for the above mentioned coverage (excluding those charges not collectable pursuant to Medicare regulation). This may include cost of collection and/or reasonable attorney fees.

IV. PATIENT FINANCIAL POLICY

I acknowledge receipt of the M&M Orthopaedics Patient Financial Policy.

I have read each of the above paragraphs and fully agree to each of the statements.
I acknowledge my agreement by signing below.

______________________________ DATE ____________________
PATIENT

______________________________ DATE ____________________
PARENT OR GUARDIAN (If patient is under 18 years of age)

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DATE ____________________

FOR OFFICE USE ONLY
ACCT# ____________________
REVIEWED BY ____________________

Welcome to our office. Please print and complete all entries

PATIENT'S FULL LEGAL NAME (LAST, FIRST, MI)	SEX	DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER
PATIENT'S STREET ADDRESS		HOME PHONE NUMBER ( )		OCCUPATION
CITY, STATE, ZIP CODE		WORK PHONE NUMBER ( )		CELLULAR PHONE NUMBER ( )
IF THE PATIENT IS A MINOR, WHO BROUGHT THEM TO THE APPOINTMENT? RELATIONSHIP:		EMAIL ADDRESS (IF THE PATIENT IS A MINOR, PLEASE INCLUDE GUARDIAN'S EMAIL ADDRESS)		

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE NUMBER ( )

PRIMARY INSURANCE POLICY HOLDER'S INFORMATION

NAME OF SUBSCRIBER (POLICY HOLDER)	SEX	DATE OF BIRTH	PATIENT RELATIONSHIP TO INSURED: o SPOUSE o FOSTER CHILD/GUARDIAN o CHILD
POLICY HOLDER'S STREET ADDRESS			HOME PHONE NUMBER ( )
CITY, STATE, ZIP CODE			SOCIAL SECURITY NUMBER
EMPLOYER			EMPLOYER'S PHONE NUMBER ( )
EMPLOYER'S ADDRESS (CITY, STATE, ZIP CODE)			OCCUPATION

SECONDARY INSURANCE POLICY HOLDER'S INFORMATION

NAME OF SUBSCRIBER (POLICY HOLDER)	SEX	DATE OF BIRTH	PATIENT RELATIONSHIP TO INSURED: o SPOUSE o FOSTER CHILD/GUARDIAN o CHILD
POLICY HOLDER'S STREET ADDRESS			HOME PHONE NUMBER ( )
CITY, STATE, ZIP CODE			SOCIAL SECURITY NUMBER
EMPLOYER			EMPLOYER'S PHONE NUMBER ( )
EMPLOYER'S ADDRESS (CITY, STATE, ZIP CODE)			OCCUPATION

PRIMARY CARE PHYSICIAN, FAMILY PHYSICIAN, or PEDIATRICIAN

NAME OF PRIMARY CARE PHYSICIAN YOU LAST HAD AN APPOINTMENT WITH	PHONE NUMBER ( )
CITY, STATE, ZIP CODE	

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PATIENT SOCIAL & FAMILY HISTORY

PATIENT'S NAME ____________________

Who referred you to this office? ____________________

Who is your Primary Care Physician? ____________________

Physician's Address:____________________ Physician's Phone Number: ____________

ALLERGIES

Please identify what you are allergic to and what type of reaction you have:

- ☐ MEDICATIONS ____________________ REACTION ____________________
- ☐ FOODS ____________________ REACTION ____________________
- ☐ IODINE (topical) ____________________ REACTION ____________________
- ☐ IODINE (injectable) ____________________ REACTION ____________________
- ☐ LATEX ____________________ REACTION ____________________
- ☐ ADHESIVES ____________________ REACTION ____________________
- ☐ OTHER ____________________ REACTION ____________________
- ☐ NO KNOWN ALLERGIES

MEDICATIONS

I take the following medications:
(All prescriptions and over-the-counter, including aspirin, herbal supplements and birth control pills):

____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

OPERATIONS, TREATMENTS, HOSPITALIZATIONS

I have had the following Operations, Treatments and/or Hospitalizations:

____________________ DATE ____________
____________________ DATE ____________
____________________ DATE ____________

SOCIAL HISTORY

Do you use any of the following assistive devices? o GLASSES o CONTACTS o HEARING AIDES
o PROSTHETIC LIMBS o CANE o WALKER

Do you smoke? (Complete if age 18 and greater)

o NO If you have quit smoking, when did you quit? (Month and year) ____________________

o YES Number of packs per day ____________ Number of years smoking ____________________

Do you use smokeless tobacco? (Complete if age 18 and greater)

o NO If you quit smokeless tobacco, when did you quit? ____________________

o YES What do you use? ____________________ Number of years using smokeless tobacco? ____________

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PATIENT'S NAME ______________________________

PATIENT SOCIAL & FAMILY HISTORY

SOCIAL HISTORY *-continued-*

Do you drink alcoholic beverages? o NO o YES—HOW OFTEN

o 1 DRINK PER MONTH o 1-2 DRINKS PER WEEK o 2-6 DRINKS PER WEEK o 6 DRINKS OR MORE PER WEEK

Do you use recreational drugs? o NO o YES (Please list) ______________________________

Are you currently pregnant? o NO o YES (Please list) ______________________________

Are you planning a pregnancy? o NO o YES (Please list) ______________________________

Evaluation for Falls (Complete if age 50 and greater)

o No falls, no injury? o Fall in past year or fall with injury? How many? ______________

o Screened for Osteoporosis (Bone Mineral Density Test, DEXA Scan)? When? ______________

Your current: Height ______________ Weight ______________

MEDICAL CONDITIONS

Have you, or your family ever had any of the following problems?

	SELF	PARENTS	SIBLINGS
Glaucoma			
Heart Disease			
Heart Attack			
High Blood Pressure			
Lung Disease			
Emphysema			
Asthma			
Ulcer			
Colitis			
Difficulty in Urinating			
Kidney, Bladder, Prostate problems			
Arthritis			
Gout			
Osteoporosis			
Rheumatoid Arthritis			
Parkinson's Disease			
Seizures			
Diabetes			
Thyroid Disorder			
Bleeding Problems			
Sickle Cell Anemia			
Hepatitis			
HIV			
Cancer (note type)			
Sleep Apnea			

PATIENT'S SIGNATURE ______________________________ DATE ______________

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