CONCORD ORTHOPAEDICS

History Form

Name: _____ Date of Birth: _____ Today's Date: _____

Height: _____ Weight: _____ Date of Injury: _____

Primary Care Physician: _____ Address _____

Who recommended this office? _____ Address _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____ ❑ Right ❑ Left ❑ Both

Current problem is the result of a(n): *Check* all that apply

❑ Car Accident ❑ Work Accident ❑ Slip & Fall Accident ❑ Other: _____

Have you had Physical Therapy for this problem? ❑ No ❑ Yes, Where? _____

PAST MEDICAL HISTORY

Do you or have you ever had: (Circle)

Cancer	Leukemia	Epilepsy	Migraine	Pneumonia	Stroke	Depression	Anxiety
Jaundice	Psoriasis	Asthma	Cataracts	Colitis	Anemia	Polio	Diabetes
High Cholesterol	Thyroid Problems	Rheumatic Fever	Kidney Disease	Stomach Ulcers	High Blood Pressure	Previous Transfusions	Heart Problems
Hepatitis	Reflux/GERD	Pulmonary Embolis/DVT		Sleep Apnea	Other:		

PAST SURGICAL HISTORY

Surgeries/Hospitalizations	Year	Complications/Problems with anesthesia

FAMILY HISTORY

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother(Mom's)	A	D		
Grandfather(Mom's)	A	D		
Grandmother(Dad's)	A	D		
Grandfather(Dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

MEDICATION

Medication	Dose	Reason for Medication	Side Effects

Are you currently under a pain management agreement? ❑ Yes ❑ No If so, with whom? _____

IMPORTANT: PLEASE COMPLETE AND SIGN NEXT PAGE! FC11

CONCORD ORTHOPAEDICS

ALLERGIES

Do you have any latex allergies? ❑ No ❑ Yes

Any known medication allergies? ❑ No ❑ Yes, Please List:

Name of Medication	Specific Reaction to this Medication

REVIEW OF SYSTEMS

Are you currently having or have you had problems with your:

	Circle		Describe all YES responses
Eyes	No	Yes	
Ears, Nose, Throat	No	Yes	
Lungs, Breathing	No	Yes	
Digestion/Bowel movement	No	Yes	
Bladder problem	No	Yes	
Bleeding problems	No	Yes	
Skin/ rashes, lesions, etc.	No	Yes	
Muscle problems	No	Yes	
Joint problems	No	Yes	
Numbness/tingling	No	Yes	
Blackout/fainting	No	Yes	
Psychological problems	No	Yes	
Arthritis	No	Yes	
TB	No	Yes	
Chest pain/irregular heartbeat	No	Yes	
HIV/AIDS	No	Yes	

Patients under 18: Birth Weight:_____ Pregnancy Duration:_____Breech? ❑ No ❑ Yes

List any pregnancy complications:_____

Scoliosis Patients: Neck and headaches ❑ No ❑ Yes Incontinence ❑ No ❑ Yes

Girls: First menstrual period:_____

SOCIAL HISTORY

❑ Work in the home ❑ Employed (occupation_____) ❑ Student ❑ Retired

❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Children? ❑ No ❑ Yes How many?_____ Do you live alone? ❑ No ❑ Yes

Exercise? ❑ Daily ❑ 2-3 Times/Week ❑ Weekly ❑ Monthly ❑ Rarely ❑ Never

What type of exercise? _____

History of substance abuse? ❑ No ❑ Yes What? _____

Smoking? ☐Current every day smoker or ☐ Current some day smoker ___ packs/day ___ year ☐ Never Smoked

☐Former smoker ☐ this year ☐ > 1 year ☐ > 5 years ☐ > 10 years. Formerly smoked ___ packs/day ___ years

Drink alcohol? ☐ None ❑ Daily ❑ 1-2 x/week ❑ 1-2 x/month ❑ 1-2 x/year

Patient/Parent/Guardian Signature Date

Physician Signature Date

CONCORD ORTHOPAEDICS

Patient Name (Please Print): _____

Date of Birth: _____

Electronic Communication Consent

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients of Concord Orthopaedics may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email address or text address from Concord Orthopaedics.

_____ (Patient initials) I consent to receive text messages from Concord Orthopaedics at my cell phone and any number forwarded or transferred to that number or emails to receive communications as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders / feedback / health information, unless I request a change in writing.

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders / information is: _____

The email address that I authorize to receive email messages for appointment reminders, feedback, and general health reminders / information is: _____

Concord Orthopaedics does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for details).

Patient Signature _____ Date _____

CONCORD ORTHOPAEDICS

Patient Name (Please Print): _____ **Date of Birth:** _____

Financial Policy

Medical Insurances:
We participate with and bill the following insurances: Aetna, Anthem, Cigna, Choice Care Network, CompNet PPO, First Health, Great-West Healthcare, Harvard Pilgrim HealthCare, Martin's Point, Medicare, MVP, NH Healthy Families, NH Medicaid, Oxford Health Plan, Private HealthCare System, Tufts, United HealthCare and Well Sense.

We will make a reasonable effort to bill other insurance companies; however there may not be any benefits or limited benefits for services provided by our physicians. Please be advised that it is your responsibility to contact your insurance company to determine your coverage prior to treatment.

Managed Care Insurances:
Our physicians may not be authorized to provide service for patients with managed care insurance without a referral from a primary care physician. Please contact your primary care physician for a referral authorization. If you do not have authorization prior to your appointment, you will be asked to sign a waiver accepting responsibility for payment should authorization be denied.

Some managed care plans allow you to obtain treatment without a referral. When you choose this option, there is usually an increased out of pocket expense to you.

Payment at Time of Service:
If you have no medical insurance, payment in full is expected at the time of service. Co-payments and co-insurances are due at the time of service. Patients with previous uncollectible balances are expected to pay before the provision of services.

In liability cases, we expect payment in full at the time of service and do not bill attorneys.

We accept cash, checks, debit cards, MasterCard, Visa, Discover and American Express.

Minors:
It is our policy that the individual who brings a child/ minor into our office and consents to treatment for services is accepting full responsibility for any balance due for services rendered.

I authorize assignment of insurance benefits to Concord Orthopaedics for the purpose of payment towards services rendered by Concord Orthopaedics.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for my account for any professional services rendered.

I have read this **FINANCIAL POLICY** and verify that all the insurance information that I have provided to Concord Orthopaedics is true, accurate and complete to the best of my knowledge.

Patient/Parent/Guardian Signature: _____

Patient/Parent/Guardian Name (print): _____ Date: _____

CONCORD ORTHOPAEDICS

PATIENT NAME: _____DATE OF BIRTH:_____

Patient Consent:

I authorize the providers of Concord Orthopaedics to administer any treatment, perform procedures and/or radiological services as deemed necessary in the diagnosis and treatment of the patient named above.

I authorize Concord Orthopaedics employees and providers to utilize my home or work phone numbers and answering machine(s) for the purpose of disclosing appointment and/or treatment information.

I authorize assignment of insurance benefits to Concord Orthopaedics for the purpose of payment towards services rendered by Concord Orthopaedics.

I acknowledge receipt of the "Notice of Privacy Practices" and consent to the use and disclosure of medical records (including records pertaining to drug and/or alcohol use, mental health, sexually transmitted disease, HIV/AIDS testing/treatment and/or other sensitive information).

I acknowledge that Concord Orthopaedics electronic health information records will be accessible to a limited number of Concord Hospital, Capital Orthopaedic Surgery Center and Speare Memorial Hospital staff to facilitate accurate and timely communication of information necessary for Concord Hospital, Capital Orthopaedic Surgery Center and Speare Memorial Hospital to provide services ordered by Concord Orthopaedics providers.

I acknowledge that Concord Orthopaedics will use reasonable means to protect the security and confidentiality of e-mail communication. However, because of the inherent risks of e-mail communication, Concord Orthopaedics can not guarantee the security and confidentiality of e-mail communication and will not be held liable for improper use and/or disclosure of confidential health information that is not caused by Concord Orthopaedics' intentional misconduct.

I understand that that some insurance carriers require that I obtain an insurance referral from my primary care provider for specialty care services prior to having medical services rendered. I acknowledge that if I do not have a referral for today's visit that I will assume full financial responsibility for the services rendered if my insurance company denies my claim for these services.

I agree that Concord Orthopaedics may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

Signature:_____Date:_____
(Patient/parent/guardian signature (Must be 18 years or older)

Disclosure of Information:

If you would like us to be able to discuss your medical care and/or billing account information with anyone other than yourself, please list the name, relationship, and telephone number below.

Name	Relationship	Telephone #
Name	Relationship	Telephone #

Concord Orthopaedics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.