



SUMMIT BONE & JOINT, PLLC

PATIENT REGISTRATION

PATIENT INFORMATION

NAME SOCIAL SECURITY # ADDRESS DRIVER'S LICENSE # STATE CITY STATE ZIP CODE E-MAIL HOME PHONE WORK PHONE CELL PHONE DATE OF BIRTH AGE MALE FEMALE MARITAL STATUS MARRIED SINGLE DIVORCED WIDOWED STUDENT YES NO EMPLOYER OCCUPATION ADDRESS PHONE # FAX #

FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME SOCIAL SECURITY # ADDRESS RELATION TO PATIENT SPOUSE PARENT OTHER CITY STATE ZIP CODE E-MAIL HOME PHONE WORK PHONE CELL PHONE DATE OF BIRTH AGE EMPLOYER OCCUPATION PHONE # FAX #

REASON FOR VISIT

DATE OF INCIDENT/ONSET INJURY YES NO WORK RELATED YES NO CLAIM # AUTO ACCIDENT YES NO CLAIM # NAME OF AUTO OR WORK-RELATED INSURANCE RESPONSIBLE FOR PAYMENT NAME ADDRESS CASE MANAGER OR ATTORNEY ADDRESS PHONE # FAX #

INSURANCE INFORMATION (PRIMARY)

INSURANCE CARRIER _____
ID # _____ **GROUP #** _____
POLICY HOLDER NAME _____ **MALE** **FEMALE**
DATE OF BIRTH _____ **SS #** _____ **HOME PHONE** _____
ADDRESS _____
RELATIONSHIP TO PATIENT **SPOUSE** **MOTHER** **FATHER** **OTHER** _____

INSURANCE INFORMATION (SECONDARY)

INSURANCE CARRIER _____
ID # _____ **GROUP #** _____
POLICY HOLDER NAME _____ **MALE** **FEMALE**
DATE OF BIRTH _____ **SS #** _____ **HOME PHONE** _____
ADDRESS _____
RELATIONSHIP TO PATIENT **SPOUSE** **MOTHER** **FATHER** **OTHER** _____

EMERGENCY CONTACT (NOT LIVING WITH YOU)

NAME _____ **PHONE #** _____
ADDRESS _____
LIVING WILL/POWER OF ATTORNEY? **YES** **NO**

PRESENT INSURANCE CARD TO RECEPTIONIST AT TIME OF APPOINTMENT IN ORDER FOR A PHOTOCOPY TO BE INSERTED IN YOUR CHART FOR FUTURE REFERENCE.

I consent to release, by the physician, of any use of my health care information regarding treatment, payment and health care operations. I further authorize payments of medical benefits to the doctor in the event insurance is filed on my behalf. I agree to pay for any items that are not covered by my insurance company, if applicable. I understand that these items will be itemized by date of service and I will be billed after insurance is filed, if applicable.

If the patient is a minor (under 18), I certify that I am the legal guardian and I authorize treatment by the Doctors/Staff of Summit Bone and Joint, PLLC.

I understand that if Workers' Compensation or another carrier is liable for my bills, my group insurance is not responsible for payment. I understand that all insurance information must be given to Summit Bone & Joint, PLLC before or at the time of appointment in order to verify insurance coverage and liability.

I understand that all referrals are my responsibility. I am ultimately responsible for any balance incurred at Summit Bone & Joint, PLLC. In the event that my balance is transferred to a collection agency or attempts are made to collect the balance using an outside source, I will be responsible for collection costs, attorney fees, and/or court costs up to and beyond the existing balance incurred at Summit Bone & Joint, PLLC.

PATIENT/RESPONSIBLE PARTY SIGNATURE **DATE**

IF YOU HAVE TROUBLE READING THIS FORM, PLEASE ASK FOR STAFF ASSISTANCE

NEW PATIENT FORM

NAME: _____ BIRTH DATE: _____ DATE: _____

FAMILY DOCTOR: _____ REFERRING DOCTOR: _____

HISTORY: AGE: _____ Right Left (handed) RACE: _____ MALE FEMALE

STUDENT: YES NO SCHOOL: _____ SPORTS: _____

JOB TITLE: _____ EMPLOYER: _____ HOW LONG? _____

PHYSICAL REQUIREMENTS AT WORK: _____

CHIEF COMPLAINT

Complaint

<input type="checkbox"/> Left <input type="checkbox"/> Right	Please describe the problem for which you are seeing the doctor. Please indicate the following: Date of Injury/When symptoms started : _____ _____ How symptoms started: _____ _____ Location/Type of pain: _____ Other Physician/Surgery: _____ _____ _____ MRI? X-ray? Nerve Studies?
<input type="checkbox"/> Shoulder <input type="checkbox"/> Knee <input type="checkbox"/> Elbow <input type="checkbox"/> Ankle/foot <input type="checkbox"/> Hand/wrist <input type="checkbox"/> Hip <input type="checkbox"/> Neck <input type="checkbox"/> Back	

HAVE YOU TRIED PHYSICAL THERAPY? YES NO WHERE? _____ HELPFUL? YES NO
HAVE YOU HAD ANY CHIROPRACTIC TREATMENTS? YES NO HELPFUL? YES NO
HAVE YOU TRIED A BRACE OR SUPPORT? YES NO HELPFUL? YES NO
HAVE YOU TAKEN PREDNISONE OR CORTISONE PILLS? YES NO HELPFUL? YES NO
HAVE YOU HAD ANY CORTISONE INJECTIONS? YES NO HELPFUL? YES NO

WHAT MEDICATIONS ARE YOU **ALLERGIC or INTOLERANT** TO? WHAT WERE THE REACTIONS? (rash, shortness of breath, itching, emergency treatments, etc.)

LATEX ALLERGY? YES NO

PLEASE LIST **ALL MEDICATIONS** YOU TAKE; INCLUDING OVER-THE-COUNTER AND HERBAL SUPPLEMENTS (TRY TO INCLUDE DOSES AND HOW OFTEN): _____

MEDICAL HISTORY FORM

NAME: _____ BIRTH DATE: _____ AGE: _____ DATE: _____

HAVE **YOU** OR A **BLOOD** RELATIVE EVER HAD ANY OF THE FOLLOWING PROBLEMS?

	YOU	FAMILY	Explain Yes Answers
High Blood Pressure	Yes	Yes	
High Cholesterol	Yes	Yes	
Heart Attack	Yes	Yes	
Congestive Heart Failure	Yes	Yes	
Coronary Art. Disease	Yes	Yes	
Stroke	Yes	Yes	
Pacemaker	Yes	Yes	
Blood Clots	Yes	Yes	
Anemia/Blood disorder	Yes	Yes	
Blood Transfusions	Yes	Yes	
Asthma	Yes	Yes	
Bronchitis/Pneumonia	Yes	Yes	
Emphysema	Yes	Yes	
Tuberculosis	Yes	Yes	tested?
Stomach Problems/Ulcer	Yes	Yes	
Diabetes	Yes	Yes	
Thyroid Problems	Yes	Yes	
Substance Abuse/Chem	Yes	Yes	
Dep. (addiction, occasional)	Yes	Yes	how often?
Hepatitis (A, B, C)	Yes	Yes	vaccinated?
Liver Problems	Yes	Yes	
Intestine/Bowel Problems	Yes	Yes	
HIV/AIDS	Yes	Yes	tested?
Sexually trans. Diseases	Yes	Yes	type:
Cancer	Yes	Yes	type:
Gout	Yes	Yes	
Multiple Sclerosis	Yes	Yes	
Osteoporosis	Yes	Yes	
Arthritis/Rheumatoid Arth.	Yes	Yes	
Prostate Problems	Yes	Yes	
Depression/Anxiety	Yes	Yes	
Psych Disorders	Yes	Yes	
Other	Yes	Yes	
Last Menstrual Cycle			Date: Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No
Age of First Menstrual Cycle			

PLEASE LIST **ALL SURGERIES OR HOSPITALIZATIONS** YOU HAVE HAD (TRY TO INCLUDE APPROXIMATE DATES AND DOCTOR'S NAME):

NAME: _____ BIRTH DATE: _____ AGE: _____ DATE: _____

HOW MANY MOTOR VEHICLE ACCIDENTS (cars, trucks, motorcycles, 4 wheelers, vans, RV's, planes, boats, jets skis, etc.)
HAVE YOU BEEN INVOLVED IN? _____ WHEN? _____ ANY INJURIES? _____
LIST: _____

SOCIAL HISTORY: Married Single Divorced Widowed U.S. CITIZEN? YES NO

Highest level of education: _____ Military Service/Branch: _____ How long? _____

Exercise	Yes	No	Type:	How Often:
Smoke	Yes	No	Daily Use:	How Long:
Tobacco/Snuff	Yes	No		
Alcohol	Yes	No	Type:	How Often:
Drugs	Yes	No	Type:	Last use:

DATE OF LAST PHYSICAL EXAM: _____ HEIGHT: _____ WEIGHT: _____

COMMENTS:

NURSE SIGN: _____ PROVIDER SIGN: _____



SUMMIT BONE & JOINT, PLLC
M.D.

Michael S. LaDouceur,

Diplomate, American Board of Orthopaedic Surgeons
Todd Warren, N.P., A.T.C.

Summit Medical Center
5653 Frist Blvd., Suite 731
Hermitage, TN 37076
Phone 615.232.3838
Fax 615.232.3833

Shoulder and Elbow
Sports Medicine
Adult Reconstruction
General Orthopaedics

MEDICAL RELEASE

The undersigned authorizes _____ to release the following information to:

Summit Bone & Joint, PLLC
5653 Frist Blvd. Suite 731
Hermitage, TN 37076
Phone: 615.232.3838
Fax: 615.232.3833

_____ Clinical Records

_____ Hospital Records

_____ X-Ray Reports

_____ Other

Patient or Legal Guardian Signature: X _____ Date: _____

Witness Signature: X _____ Date: _____



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MANAGED CARE AND THIS OFFICE

Dear Patient:

To avoid confusion with our patients and our office regarding your health insurance carrier, the following information is provided as a guide to our office referral system including, but not limited to: X-ray, C-T, MRI, surgery and physician referrals (both to and from this office). Preauthorization is often required before we can see patients.

While we promise to make every effort to refer patients to properly credentialed providers, we simply cannot take sole responsibility for 100% accuracy for all our referrals. There needs to be joint responsibility between us (the office) and you (our patients) to be certain that everything is done within the limits of your insurance policy.

In addition to assistance with referrals, please review the following office policies:

- **Office Hours-** Our office hours are Monday and Wednesday 7:30-5:00, Tuesday and Thursday, 8:00-5:00 and Friday 7:30-4:00.
- **Medication Guidelines-** If you experience adverse affects of any medication, STOP taking it immediately. If you are rapidly becoming ill, report to the nearest emergency room or call emergency services (911). Please call the office one full business day BEFORE your prescription needs refilling. If the call is received late Friday, it may be the first of the following week before the refill is authorized. Provide us with the phone and fax numbers of the pharmacy you desire. Refills are called in between 4 and 5 p.m., so check with the pharmacy after those times to pick up the prescription. The amount given and the strength of medication prescribed will be reduced during the recovery process. Narcotics will not be prescribed on a long-term basis.
- **Medical Records/Form Completion-** Request for records needs to be in writing. Records request and completion of forms incurs a \$20 fee, payable in advance by cash or credit card.
- **Non-Sufficient Funds-** Checks returned for non-sufficient funds will incur a \$20 fee in addition to the amount of the original check. Only cash or credit cards may be used to clear the returned check. If two NSF checks are incurred, no further personal checks will be accepted by our office.
- **Co-payments-** Your insurance requires your co-payment be collected at the time of service. If not paid at that time, a \$5 fee will be added to the original co-payment or the visit will need to be rescheduled.
- **X-rays-** We request 24 hour notice for x-rays to be copied/burned to a CD-R.

We want to thank you for choosing Summit Bone and Joint, PLLC, for treatment and thank you in advance for your help regarding referrals and reviewing our office policies. Please call our staff with any comments or questions.

Patient Signature

Date