



Entered by \_\_\_\_\_

Scanned by \_\_\_\_\_

**PATIENT INFORMATION**

NAME \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_  
ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_  
CELL PHONE \_\_\_\_\_  
EMAIL ADDRESS \_\_\_\_\_

EMPLOYER OR SCHOOL \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
PHONE \_\_\_\_\_

IF RETIRED, WHERE FROM \_\_\_\_\_  
PLEASE LIST ANY NAME CHANGES IN THE PAST 10 YEARS  
\_\_\_\_\_  
\_\_\_\_\_

MARITAL STATUS  Single  Married  
SOCIAL SECURITY # \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_  
NEAREST RELATIVE/FRIEND \_\_\_\_\_  
(NOT LIVING WITH YOU)  
RELATIONSHIP TO PATIENT \_\_\_\_\_  
THEIR PHONE \_\_\_\_\_  
THEIR CELL \_\_\_\_\_  
THEIR WORK \_\_\_\_\_

DO YOU HAVE CALLER ID OR VOICE MAIL  YES  NO  
HAVE YOU SEEN OUR DOCTORS IN THE PAST  YES  NO

**ARE YOU CURRENTLY LIVING IN A NURSING HOME OR IN-PATIENT REHAB FACILITY?**  YES  NO

FACILITY NAME \_\_\_\_\_  
FACILITY PHONE \_\_\_\_\_

WHERE IS YOUR PAIN OR INJURY LOCATED? \_\_\_\_\_  
HOW LONG HAVE YOU HAD THE PROBLEM? \_\_\_\_\_  
APPROXIMATE DATE \_\_\_\_\_

WERE X-RAYS, MRI, SCANS OR ANY TESTING TAKEN?  YES  NO IF YES, WHERE \_\_\_\_\_  
(YOU MUST HAVE THE **REPORTS & ACTUAL FILMS OR DISK** (IF NOT FROM ST. MARY'S OR DEACONESS) WITH YOU AT THE TIME OF THE APPOINTMENT. IF NOT YOUR APPOINTMENT: MAY BE RESCHEDULED)

IS THERE ANY POSSIBILITY OF PREGNANCY?  YES  NO

LAST DAY WORKED \_\_\_\_\_

INJURY OR ACCIDENT DATE \_\_\_\_\_ AUTOMOBILE INVOLVED? \_\_\_\_\_ OTHER \_\_\_\_\_  
IN WHAT STATE DID THE ACCIDENT OCCUR? DESCRIBE ACCIDENT \_\_\_\_\_

WERE YOU INJURED ON THE JOB? CLAIM OR FILE # \_\_\_\_\_  
IF INJURED ON THE JOB. YOU MUST BRING A LETTER OF AUTHORIZATION FROM THE COMPENSATION CARRIER OR EMPLOYER. IF UNABLE TO PROVIDE. YOU MAY BE HELD RESPONSIBLE FOR ANY CHARGES THE DAY SERVICE IS RENDERED.

**SPOUSE/PARENT INFORMATION**  
**THIS SECTION MUST BE FILLED OUT COMPLETELY**

IF MARRIED, HUSBAND'S NAME \_\_\_\_\_  
IF DEPENDENT, FATHER'S NAME \_\_\_\_\_  
PHONE ( ) \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
WORK PHONE ( ) \_\_\_\_\_

IF MARRIED, WIFE'S NAME \_\_\_\_\_  
IF DEPENDENT, MOTHER'S NAME \_\_\_\_\_  
PHONE ( ) \_\_\_\_\_  
SOCIAL SECURITY # \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
WORK PHONE ( ) \_\_\_\_\_

**HEALTH INSURANCE**

PRIMARY INSURANCE \_\_\_\_\_  
SECONDARY INSURANCE \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_  
POLICY HOLDER \_\_\_\_\_

**HIPAA** I acknowledge that I have received or have been offered the Tri-State Orthopaedic Surgeons Inc. "Notice of Privacy Practices".

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**Records Release** I HEREBY AUTHORIZE ANY INFORMATION INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME TO BE RELEASED TO TRI-STATE ORTHOPAEDIC SURGEONS, INC.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**CONSENT TO RELEASE INFORMATION**

List any family members or friends that you would want to be able to pick up the following for you: medical records, X-Rays or CD'S, or Prescriptions.

Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____

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**I HAVE READ THIS FORM AND I UNDERSTAND ALL INFORMATION TO BE TRUE**

All patients under the age of eighteen (18) will need a parent or legal guardian in attendance at the appointment, before medical care can be provided

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. All charges are due and payable at the time services are rendered unless other arrangements have been made in advance with Patient Account Services.

**I, the patient/guardian am responsible for all fees, regardless of insurance coverage.**  
**I, the patient/guardian authorize the release of any medical or other information necessary to process my claims.**  
**I, the patient/guardian authorize direct payment of the medical benefits to Tri-State Orthopaedic Surgeons, Inc. and/or any supplier of the service representing Tri-State Orthopaedic Surgeons, Inc.**

"I understand that interest will be incurred on the unpaid PATIENT portion of this account. To avoid accrual of interest, I understand patient balances should be paid within 30 days of the date of billing. I agree to pay all interest and collection costs, including attorney and court fees, if Tri-State Orthopaedic Surgeons, Inc. sends my account to a collection agency or attorney for collection. Jurisdiction for the collection of this debt lies within Vanderburgh County, Indiana."

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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**REFERRAL WAIVER RELEASE**

For Treatment Without A Referral

The above named patient has presented him/herself to me for the treatment without a referral from a Primary Care Physician (which is required by his/her insurance company). The patient has chosen to keep this appointment and understands that if the referral is not obtained, he/she is responsible for payment.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_