REFERRAL SOURCE	
	☐ Patient
	☐ Radio
	☐ TV
	☐ Website
	☐ Physician
	☐ Hospital
	☐ Self Referral
	☐ Other Advertisement

TRI-STATE ORTHOPAEDICS

Account#: _____

PATIENT INFORMATION

NAME _____ MARITAL STATUS ☐ Single ☐ Married
HOME ADDRESS _____
CITY _____ STATE _____ SOCIAL SECURITY #_____
ZIP _____

DATE OF BIRTH _____
1st PHONE _____ ☐ Home ☐ Cell ☐ Work NEAREST RELATIVE/FRIEND _____
2nd PHONE _____ ☐ Home ☐ Cell ☐ Work (NOT LIVING WITH YOU)
3rd PHONE _____ ☐ Home ☐ Cell ☐ Work RELATIONSHIP TO PATIENT _____
EMAIL ADDRESS _____ THEIR PHONE _____

EMPLOYER OR SCHOOL _____ HAVE YOU SEEN OUR DOCTORS IN THE PAST ☐ YES ☐ NO
ADDRESS _____
IF RETIRED, WHERE FROM _____ **ARE YOU CURRENTLY LIVING IN A NURSING HOME OR IN-PATIENT REHAB FACILITY?** ☐ YES ☐ NO
PLEASE LIST ANY NAME CHANGES IN THE PAST 10 YEARS

_____ 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 PREGNACY? ☐ 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 MARRIED, WIFE'S NAME _____
IF DEPENDENT, FATHER'S NAME _____ IF DEPENDENT, MOTHER'S NAME _____
PHONE ( ) _____ PHONE ( ) _____
SOCIAL SECURITY # _____ SOCIAL SECURITY # _____
DATE OF BIRTH _____ DATE OF BIRTH _____
ADDRESS _____ ADDRESS _____
EMPLOYER _____ EMPLOYER _____
WORK PHONE ( ) _____ WORK PHONE ( ) _____

HEALTH INSURANCE

PRIMARY INSURANCE _____ POLICY HOLDER _____

SECONDARY INSURANCE _____ POLICY HOLDER _____

ETHNICITY ☐ Hispanic or Latino
☐ Non Hispanic or Latino
☐ Patient Declined

LANGUAGE _____

RACE ☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Patient Declined

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

Signature _____ Date _____

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

Signature _____ Date _____

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 _____

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 _____

REFERAL 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 _____