DOSM Danville Orthopaedics & Sports Medicine

SHELBY T. WHITE, MD
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JEREMY D. CAUDILL, PA-C

Your appointment date and time: _____

with: _____**. Please arrive 20 minutes early.**

Danville _____ **333 South 3rd St, Ste B, Danville, Ky 40422**

Russell Springs _____ **92 JT Petty Dr, Russell Springs, Ky 42642**

Lexington _____ **216 Fountain Ct, Ste 250, Lexington, Ky 40509**

Harrodsburg _____ **470 Linden Ave, Harrodsburg, Ky 40330**

Welcome _____ to Danville Orthopaedics and Sports Medicine, PSC. We are happy that you have chosen us to provide your Orthopaedics care.

Enclosed are a Registration Form, Notice of Privacy Practices, Health History Form and a Medication List Form which will be required on your appointment date. Please complete and bring with you. **Please do not mail these back to us as we do not pre-register.** The Notice of Privacy Practices must be signed and a copy of our policy will be made available to you upon request.

If you have had x-rays related to your problem bring these with you. Russell County/Harrodsburg patients: If an X-ray order is included in your packet, please go to Russell County Hospital/Haggin Hospital the day before or the morning of your appointment for x-ray. **If your films were taken at any of the following locations we can access these from our office, therefore you would not need to bring the films.**

- Ephraim McDowell or any associated facilities (ie..Southtown, Danville Family Physicians, etc…)
- James B. Haggin
- Fort Logan
- Central Ky Diagnostic Center
- Russell County Hospital

Also please note that you will need to bring your insurance card(s) with you to your appointment. If you cannot provide proof of insurance within two weeks of date of treatment payment responsibility will be transferred to you. If your insurance required a referral make sure this is obtained. Payment of any co-pay if required on the day you are seen. We also ask that you bring your Drivers License/ID.

If you are **self-pay** there is a deposit of $100 if you have had x-rays or $150 if you have not had x-rays. All deposits must be paid on the day you are seen. Deposits must be paid by cash, credit card or money order. If this payment is not made your appointment will be cancelled and rescheduled. If charges exceed the amount you have been asked to bring and payment cannot be made in full that day or by your next appointment a payment plan can be set up.

If you have any questions that are not addressed in this letter please give us a call at (859)236-8730 before your appointment.

Again, thank you for choosing Danville Orthopaedics and Sports Medicine, PSC. We look forward to serving you. Please visit our website www.danortho.com for additional information.

Danville Orthopaedics & Sports Medicine Physicians and Staff
(859)236-8730 phone
(859)236-4468 fax

DANVILLE ORTHOPAEDICS and SPORTS MEDICINE

333 S. Third Street, Suite B
Danville, KY 40422
Phone: (859) 236-8730 • Fax: (859) 236-4468

PATIENT INFORMATION

NAME (last, first, middle)	Social Security #	Date of Birth	Sex M___ F___
HOME ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	ALT PHONE	

MARITAL STATUS: ___ Single ___ Married ___ Divorced ___ Widowed ___ Life Partner

Student Status: ___ Full-Time Student ___ Part-Time Student ___ Not a Student

VETERAN: ___Yes ___No

SMOKER: ___No ___Yes If so, how many packs/day?_____ How many years? _____

RACE:

___White ___ African American ___Hispanic ___ Asian ___Indian ___Multicultural ___Native American Indian ___ Pacific Islander

ETHNICITY:

___ Hispanic ___Non-Hispanic

LANGUAGE:

___ English ___ Spanish ___ American Sign Language ___Other: _____

PRIMARY EMPLOYER	WORK PHONE
EMPLOYER ADDRESS	CITY, STATE, ZIP CODE

PHYSICIAN INFORMATION

REFERRING PHYSICIAN: _____ FAMILY PHYSICIAN: _____

EMERGENCY CONTACT INFORMATION

NAME (last, first, middle)	RELATIONSHIP TO PATIENT
ADDRESS (street, city, state, zip)	PHONE NUMBER

RESPONSIBLE PARTY INFORMATION (if different than patient)

NAME (last, first, middle)	SSN #	DOB	Sex M___ F___
HOME ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	ALT PHONE	

RELATIONSHIP TO PATIENT: ___Parent___Guardian___Spouse___Other:_____

PLEASE TURN THIS FORM OVER TO CONTINUE

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333 S. Third Street, Suite B
Danville, KY 40422
Phone: (859) 236-8730 • Fax: (859) 236-4468

INSURANCE INFORMATION

PLEASE CHECK IF YOUR INJURY RELATED TO: ___ WORKERS COMP ___ AUTOMOBILE ___ LIABILITY

DATE OF INJURY	CLAIM NUMBER	CLAIMS ADJUSTER NAME/PHONE NUMBER

PRIMARY INSURANCE

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER

POLICYHOLDER'S NAME (if different than patient)	DOB	SSN

INS CLAIMS MAILING ADDRESS (if Worker's Comp / Auto / Liability)	CITY	STATE	ZIP CODE

SECONDARY INSURANCE (if applicable)

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER

POLICYHOLDER'S NAME (if different than patient)	DOB	SSN

OTHER INSURANCE (if applicable)

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER

POLICYHOLDER'S NAME (if different than patient)	DOB	SSN

I hereby authorize Danville Orthopaedics and Sports Medicine to release any medical information necessary for treatment coordination and/or billing purpose. I further authorize and permit payment by my insurance company directly to Danville Orthopaedics and Sports Medicine for services provided by them. I recognize and accept financial responsibility for payment of services regardless of Insurance coverage. This includes, but is not limited to, co-insurance, co-payments, deductibles, and non-covered services.

SIGNATURE: _____ **DATE:** _____

Consent and Acknowledgment of Receipt of Notice of Privacy Practices for Purposes of Payment and Healthcare Operations

I consent to the use of disclosure of my protected health information by Danville Orthopedics & Sports Medicine, PSC for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Danville Orthopedics & Sports Medicine, PSC.

I have the right to revoke this consent, in writing, at any time, except to the extent that Danville Orthopedics & Sports Medicine, PSC has acted in reliance to this consent.

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse.

I understand I have the right to review Danville Orthopedics & Sports Medicine, PSC Notice of Privacy Practices (NPP) prior to signing this document. The NPP has been provided to me and copes are available at the check-in window in the lobby. The NPP describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Danville Orthopedics & Sports Medicine, PSC. This NPP also describes my rights and Danville Orthopedics & Sports Medicine, PSC duties with respect to my PHI.

Electronic format: I acknowledge that my records are stored in an electronic format. Original documents may be destroyed after being converted to an electronic format.

Danville Orthopedics & Sports Medicine, PSC reserves the right to change the privacy practices that are described in the NPP. I may obtain a revised NPP by calling the office and requesting one to be mailed or asking for one at my next appointment. I acknowledge I have been offered a free copy of the NPP.

Release of information: I hereby give Danville Orthopedics & Sports Medicine, PSC permission to release information on my medical condition to the following people:

_____

_____

(Name and relationship)

I understand the areas discussed with these people could include treatment options, appt information, side effects, prescriptions, financial information, test results, etc.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient of Personal Representative

_____

Description of Personal Representatives Authority (POA, Parent, etc.)

Parent or Personal Representative refused to sign acknowledgement

_____ Staff Initials

_____ Date

** I would like to restrict disclosures to the "Insurance Company" for services paid in full by me.

Date of Service: _____

Patient Signature: _____

Danville Orthopaedics & Sports Medicine Medical History

Name: _____ Referred by: _____

Date of Birth: _____ Age: _____ Date: _____

Why are you here today? _____

When did it start? _____

Medical History

List your medical problems (such as diabetes, high blood pressure, heart attack, etc.):

_____ _____

_____ _____

Do you take any medications: ____ Yes ____ No Height _____ Weight _____

Are you allergic to any medications? ____ Yes ____ No

If yes, check choices below:

___ Aspirin ___ Codeine ___ Sulfa ___ Penicillin ___ Keflex ___ Latex ___ Local Anesthetic

___ Other - please list: _____

For women: Are you taking birth control pills? _____ Are you pregnant? _____

Surgical History

Have you ever had surgery? ____ Yes ____ No

Type of Surgery	Year	Type of Surgery	Year

If you have had surgery, have you ever had problems with anesthesia? ____ Yes ____ No

If yes, explain: _____

_____

_____

Please turn over the form and complete the other side.

For office use only: (Reviewed by: _____ Date: _____)

Family Hiistory

	Alive	Deceased	Age	Health status/cause of death
Father	A	D	____	_____
Mother	A	D	____	_____
Sister/Brother	A	D	____	_____
Sister/Brother	A	D	____	_____
Sister/Brother	A	D	____	_____

Social History

Marital status: __Married __Separated __Divorced __Single __Widowed
Work status: __Full-time __Part-time __Disabled __Retired
Occupation: _____ Employed by: _____
Do you smoke currently? ___Yes ___No _____ packs per day for ___ years
Have you quit smoking? ___This year ___>1 year ___>5 years ___>10 years
Previously smoked____ packs per day for ____ years
Do you drink alcohol ___Daily ___1-2 times/week ___never How much? _____

Review of Systems:
Please check below those areas in which you have had medical problems. If you have had no significant medical problems, check here: ❑ None

Check if Applicable

Constitutional
- ❑ fatigue
- ❑ fever
- ❑ night sweats
- ❑ weight gain (unintentional)
- ❑ weight loss (unintentional)

Eyes
- ❑ blurred vision
- ❑ eye pain
- ❑ glasses/contacts

Ears/Nose/Throat
- ❑ ear pain
- ❑ hearing problems
- ❑ nasal congestion
- ❑ bleeding gums
- ❑ dentures present
- ❑ hoarseness
- ❑ tooth pain

Cardiovascular
- ❑ chest pain
- ❑ pain in legs while walking
- ❑ shortness of breath when laying flat
- ❑ palpitations, irregular heartbeat
- ❑ rapid irregular heart rate
- ❑ venous blood clots

Respiratory
- ❑ cough (chronic)
- ❑ shortness of breath
- ❑ sharp chest pain with breathing
- ❑ wheezing

Gastrointestinal
- ❑ abdominal pain
- ❑ acid reflux
- ❑ loss of appetite
- ❑ difficulty swallowing
- ❑ constipation, diarrhea
- ❑ heartburn
- ❑ nausea or vomiting

Genitourinary
- ❑ pain with urination
- ❑ blood in urine
- ❑ hx frequent UTI's
- ❑ frequency of urination at night
- ❑ excessive urination
- ❑ urinary incontinence

Musculoskeletal
- ❑ joint aches, pains, stiffness
- ❑ back pain
- ❑ muscle aches and pain

Infections
- ❑ History of MRSA (staph infection)

Skin Breast
- ❑ worrisome skin lesion
- ❑ acne or pimples
- ❑ rashes
- ❑ breast mass
- ❑ nipple discharge

Neurological
- ❑ fainting, dizziness
- ❑ headaches
- ❑ seizures
- ❑ tremor
- ❑ vertigo (spinning dizziness)

Hematological
- ❑ excessive bleeding
- ❑ hx of blood transfusion

Endocrine
- ❑ heat/cold intolerance
- ❑ excessive hair growth or loss
- ❑ excessive thirst

Allergic/Immunologic
- ❑ seasonal allergies/"hay fever"
- ❑ hives with medicine

Psychiatric
- ❑ depression, anxiety
- ❑ excessive mood swings
- ❑ sleep disturbance

What else should we know about your medical condition? _____

Thank you for providing this important information for us.

For office use only: (Reviewed by: _____ Date: _____)

(Rev. 3/25/08)

Physician Record Documentation Sheet

MRN #__________________

Patient Name: __________________________________

Date: ____________________

DOB: __________________ Age: _________ Sex: ____________

Please list all current medications (**Please list prescriptions first then over the counter medications, herbals, vitamins and supplements**):

Medication Dose/Frequency/Route	Medication Dose/Frequency/Route

Clinician Initials: _______ Date: ________	Clinician Initials: _______ Date: ________	Clinician Initials: _______ Date: ________
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