MAIN LINE ORTHOPAEDICS, P.C.

(Please Print Clearly and Answer All Questions)

Full Name_____ **Appt. Date**_____
(FIRST) (MI) (LAST)

Street Address _____

City_____ **State**____ **Zip Code**_____

Home Phone_____ Cell Phone_____ Work Phone_____

Social Sec.# _____ Age_____ Birthdate_____

Marital Status _____ Pregnant _____ **Email Address**_____

Place of Employment_____

Street Address_____City_____State___Zip_____

Job Title_____

Emergency Contact Name _____Emergency Phone_____

Address _____

Emergency Work Phone _____Relationship to Patient_____

Primary Care Physician _____Phone_____ Fax_____

Street address_____City_____State_____Zip_____

Referred to our office by_____

Is this a Workers Compensation Claim? _____ Auto Accident? _____
(Please fill out separate form for either of these)

PHARMACY NAME: _____
STREET ADDRESS: _____
CITY: _____**STATE:** ____**ZIP:**_____
PHONE NUMBER: _____

INSURANCE INFORMATION: <u>PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST</u>

IF SUBSCRIBER IS DIFFERENT FROM PATIENT:

Subscriber's Name _____

Employer_____ Birthdate_____
Social Security Number_____

<u>I HAVE RECEIVED A COPY OF THE "HIPAA NOTICE OF PRIVACY PRACTICE"</u>

_____ **Signature**

MAIN LINE ORTHOPAEDICS, P.C.
INTAKE FORM

NAME _____ **APPOINTMENT DATE** _____

Chief Complaint: (What is the problem? Example: right knee pain, left shoulder pain, arthritis, etc):

_____

_____

History: (How and when did your problem begin?)

_____

_____

Please indicate any treatments you have had so far: (Check all that apply)

____None ____Injections ____Physical Therapy (how long and where) _____

____Surgery (when and where) _____

____Medications (for this problem) _____

Please categorize your pain: (Please circle one) none mild mild to moderate

moderate moderate to severe severe unbearable

My pain is: (Please circle all that apply) constant intermittent achy burning

deep superficial improving worsening

Modifying factors (What makes your pain better or worse? Please check all that apply)

____Better with activity ____Worse with activity ____Better with rest ____Worse with rest

____Better with sleep ____Worse with sleep ____better with medicines ____Nothing

____Changing positions help (describe):_____

Past Medical History (Please check all that apply): ____**NEGATIVE**

____arthritis	____fibromyalgia	____gout	____hearing loss	____stroke
____coronary disease	____heart attack	____arrhythmia	____asthma	____COPD
____high blood pressure	____GERD	____ulcers	____thyroid disease	____hepatitis
____cancer	____anemia	____diabetes	____colitis	____neuropathy
____excessive bleeding	____DVT (clots)	____osteoporosis	____pulmonary embolism	

Past Surgical History (Please list any prior surgeries and approximate dates): ____**NEGATIVE**

_____

_____

If you have had surgery, have you had any problems with anesthesia? Please explain:_____

_____

Do you have any of the following problems? (Please check all that apply) ____**NONE**

____abdominal pains
____balance/dizziness problems
____blurred vision
____body aches
____burning with urination
____chest pains or tightness
____chills/fever
____chronic cough
____constipation/diarrhea
____depression
____difficulty with urination
____headache
____hearing loss
____heart palpitations
____heartburn (reflux)
____mood swings
____nausea or vomiting
____pain in multiple joints
____recent weight gain or loss
____shortness of breath
____skin bruising
____skin rashes
____sore or dry throat
____swelling in arms or legs

Family History (Does anyone in your family have a history of the following?) Please check all that apply:

____arthritis ____stroke ____osteoporosis ____hearing loss ____mult. fractures
____coronary disease ____heart attack ____arrhythmia ____asthma ____COPD
____high blood pressure ____GERD ____ulcers ____thyroid disease ____hepatitis
____cancer ____anemia ____diabetes ____colitis ____neuropathy
____substance abuse ____DVT (clots) ____pulmonary embolism ____anesthesia problems

Social History: (Please check the appropriate space):

Smoking History ____none ____less than one pk/day ____one pk/day ____two pks/day
____more than two pks/day ____prior smoker who quit…when?_____

Alcohol Use ____none ____socially ____daily.
If daily how much and what do you drink_____

Recreational Drugs Please list any recreational drug use_____

History of substance abuse? ____No ____Yes. Explain_____

Drug Allergies (Please check or list others): ____**NONE**

____penicillin ____keflex or cephalosporins ____sulfa ____IVP dye

____aspirin Others:_____

Current Medications (**PRINT CLEARLY** and list all medications or supply us with a separate list): ____**NONE**

_____

_____

_____

Please list your height and weight: **Height**_____ **Weight**_____

DO NOT WRITE BELOW THIS LINE

Notes: (for office use only):_____

_____

_____

_____

_____

Joseph V. Vernace, M.D.
Hip, Knee & Shoulder
Joint Replacement
Arthroscopy

Sara "Stevie" Jackson, P.A.-C.
Physician Assistant

Founder's Physical Therapy, LLC
Suite 202
Tel 610.527.3300
Jane M. Smith, M.S. P.T.
Amy L. Carroll, P.T., D.P.T.
Amy C. Lukasiewicz, M.S.P.T., O.C.S.

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, authorize Main Line Orthopaedics, PC to disclose the information listed, to the individuals listed below. **This disclosure is not for physicians but for family members, friends, etc.**

I understand that information disclosed to these individuals may re-disclose information inadvertently to other parties. The privacy of this information may not be protected under the federal privacy regulations. This practice does not take responsibility for any disclosure made by the individuals listed below.

You may revoke or terminate this authorization by submitting your request in writing. Please contact the Privacy Officer if you should wish to terminate or change this authorization at a later date.

***I authorize the disclosure of the following information: (All information or certain items in your chart)**

_____

_____

_____

_____

***Information described above may be disclosed to: (family member, friend, etc)**

_____
Name of Person and Relationship to patient or Name of Organization

_____
Name of Person and Relationship to patient or Name of Organization

_____
Name of Person and Relationship to patient or Name of Organization

_____ _____
Patient Signature Date

PLEASE READ AND SIGN

TO ALL OUR PATIENTS

1. Please let us know if your address, phone number or insurance plan has changed.

2. We will need to see your insurance card at every visit.

3. Your copay is expected at the time of your visit.

4. ***If you have a deductible you will be asked to pay a portion of your office visit.***

5. Our office accepts....MasterCard, Visa, American Express and Discover cards.

6. Your insurance plan is a contract between you and your insurance company and according to your carrier, you must follow your insurance company guidelines as far as paying your portion of your visit.

7. It is YOUR responsibility to make sure you have a referral to cover your office visit. **If you do not have a referral for your visit, you will be charged.**

8. Our statements are sent out on a monthly billing cycle and we expect payment on receipt of our statement.

9. If you have ANY questions regarding your bill, please call Lori P at 1-800-322-4606 and she will be happy to answer any of your questions or concerns.

10. If you receive 3 bills and there is no payment, your account will be turned over to our Office Manager. Please do not let this happen to your account.

11. There will be a $30.00 fee added to your account for any returned checks.

12. If you are here for your post op appointment and you have a medical problem or issue you would like to talk to the doctor about, please understand what this might mean in terms of payment and billing. We will submit the appropriate billing code to your insurance (or bill you directly if you are uninsured). You may be responsible for a copay after the claim is processed.

13. If you come for a 3 month post op visit and it is past the 90 day post op time (for most but not all surgeries) allowed by your insurance company you WILL be charged a copay.

I have read and understand the above information

PRINT NAME_____SIGN_____DATE_____

DATE OF BIRTH _____

MAIN LINE ORTHOPAEDICS, PC
101 S. BRYN MAWR AVENUE
SUITE 200
BRYN MAWR, PA 19010
610-527-9500 Phone
610-527-9529 Fax

MAIN LINE ORTHOPAEDICS, PC

ASSIGNMENT AND RELEASE OF INFORMATION

PATIENT NAME (PLEASE PRINT)_____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to Main line Orthopaedics, P.C. I also authorize Main Line Orthopaedics, P.C to release any information required to process my claim.

I further understand that I am financially responsible for any balances not covered by my insurance carrier.

If this is a Workers Compensation/Motor Vehicle Claim I also authorize Main Line Orthopaedics, P.C to supply any and all information pertaining to my compensation claim to both the insurance carrier as well as my employer.

SIGNATURE:_____ **DATE:**_____

If you would like a copy of your x-rays we will need at least 24 hours to have them ready for you to pick up.