NorthCrest
PHYSICIAN ◆ SERVICES

Patient Information
(Please Print)

Today's Date:

Patient Name:			Social Security:	Patient Sex:
Street Address:			Race:	Ethnic:
City:	State:	Zip code:	Date of Birth: / Age: years	Marital Status: Unknown
Cell Phone:	Home Telephone:	Work Telephone:	Name of Spouse if Married:	

Patient Employer	**Employer Name:**	**Employer Telephone Number:**	
	Employer Street Address:	**Occupation:**	
	Employer City:	**Employer State:**	**Employer Zip:**
Emergency Contact	**Patient Emergency Contact:**	**Emergency Home Telephone:**	
	Street Address:	**Emergency Work Telephone:**	
	City: / **State**	**Zip:**	**Relationship to Patient:**
Insured	**Subscriber Name:** **Insurance Name:**	**Relationship to Patient:**	
	Insurance ID: **Insurance Phone:** / **Sex:**	**Subscriber Date of Birth:**	**Age:**
	Subscriber Employer:	**Work Telephone Number:**	

Contacting You (Circle which applies)	**May we leave a message concerning appointments on:** 6155457570	**Home**	**Cell**	**Work**	**Emg. Contact**	**None**

Release of Information	**Tell us who we can release Medical information to?**	**Name:**	**Phone number:**
		Name:	**Phone number:**

Advance Directives	**An Advance Directive is a document that explains your choice of treatment regarding a disabling illness. These documents are called Living will and Durable Power of Attorney for Healthcare. If you have these documents, please provide a copy to our office to be included in your medical records.**	**Living will**	**Yes**	**No**
		Durable Power of Attorney	**Yes**	**No**
		Have you provided a copy of these forms to our office?	**Yes**	**No**

The Information above is correct to the best of my knowledge. I understand that NorthCrest Physician Services files insurance as a courtesy and if for any reason insurance denies payment I am financially responsible for all charges associated with my visit.

Signature of Patient (Legal Guardian if Patient is a Minor): ______________________ ____________ **Date**

Primary Care Physician:

NorthCrest Orthopedics

Name: ______________________________

Email Address: ______________________________

Place of Employment: ______________________________

Reason for Visit

What is the reason for your visit today? ______________________________

When did you first notice this problem? ______________________________

Is this injury work related? ______________________________

Location of the problem? ______________________________

Is the problem painful? o Yes o No If so, what is the intensity? "O" being no pain: 0 1 2 3 4 5 6 7 8 9 10

Is the pain: o Sharp oDull oConstant oIntermittent

Are you currently being seen for Pain Management? oYes oNo If Yes, where? ______________________________

Does it interfere with regular activities? oYes oNo

What makes it worse? ______________________________

What makes it better? ______________________________

Have you had this problem before? oYes oNo When? ______________________________

If so, did you receive treatment? oYes oNo What Physician did you see? ______________________________

Social History

Do you smoke? oYes oNo How many packs per day? ______

Do you drink alcohol? oYes oNo How much per day? ______________

Do you use street drugs? oYes oNo What kind and how often? ______________

Patient Medical History

Do you have or have you ever had any of the following:

- o High Blood Pressure
- o Thyroid Problems
- o Emphysema/COPD/Asthma or other lung issues
- o Painful or frequent Urination
- o Cancer What type?
- o Heart Failure
- o Diabetes
- o Arthritis
- o Lack of bladder control
- o Heart Attack
- o HIV
- o Prostate Problems
- o Kidney Disease/Failure
- o Stroke
- o Hepatitis

What Pharmacy do you use: ______________________________ Pharmacy Phone # __________________

Please list **ALL** medications:

Name of Medication	Dosage	How often

Allergies: Please check all that apply

○ None ○ Codeine ○ Penicillin ○ Morphine ○ Novocaine ○ Iodine ○ Latex ○ Adhesive/Tape
○ Demerol ○ Sulfa ○ Aspirin ○ Local Anesthetics ○ Seafood ○ Foods ______________________

Please list **ALL** surgeries:

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NorthCrest

Physician ♦ Services, Inc.

CONDITIONS OF ADMISSION AND AUTHORIZATION FOR MEDICAL TREATMENT

I. **CONSENT FOR MEDICAL PROCEDURES AND TREATMENT**
Medical Consent for Treatment: Permission is hereby granted to NorthCrest Physician Services, Inc. for medical treatment as may be deemed necessary by my physician and/or his or her designee. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me as to the results of treatments, or examinations.

I. **NOTICE OF PRIVACY PRACTICES**
I acknowledge, upon request, I can receive a copy of the NorthCrest Physician Services' Notice of Privacy Practices. I understand that if I have questions or complaints, I may contact the Practice Manager of NorthCrest Physician Services at (615) 382-5851.

II. **RELEASE OF INFORMATION**
I authorize NorthCrest Physician Services physicians involved in my care to release medical information and supporting documentation of same as compiled in my medical records to any organization which is or may be liable or responsible for payment of charges associated with my care and for all other purposes of benefit payment. If my injury is work related, I authorize NorthCrest Physician Services to release any information from my medical records to my employer and/or its designee. I acknowledge that data from my patient records will be accessible to all health care providers participating in my care or treatment, including but not limited to physicians, nurses, and technicians at the hospital, home health agencies, physical therapy centers and such other health care agencies involved with my care.

III. **Assignment of Benefits**
This assignment of benefits allows NorthCrest Physician Services Physicians to be paid directly by my health insurance carrier or other health benefit plan for the services NorthCrest Physician Services Physicians provide to me, my minor child, or other person entitled to health care benefits for this office visit.

IV. **Financial Agreement**
In consideration of the services to be rendered to the patient, the undersigned (as parent, guardian, spouse, guarantor, agent or as the patient) individually promises to pay the patient's account at the rates stated in NorthCrest Physician Services' price list (known as the "Charge Master") effective on the date of service. In the event that NorthCrest Physician Services has to engage an attorney or collection agency to collect any unpaid balances that arise from the treatment consented herein, the undersigned agrees to pay the reasonable attorney's fees and collection expenses incurred by NorthCrest Physician Services.

It is the responsibility of the patient, the undersigned (as parent, guardian, spouse, guarantor, and agent or as the patient) to let the physician's office know at the time of service if your insurance has changed. All co-payments and deductibles are expected to be paid at the time of service. I understand that if I have a co-payment according to my insurance policy, I am responsible for making this payment at the time of each visit to the office. I further understand that failure to make this payment at time of service will result in my visit being rescheduled.

V. **Medicare Patient Certification**
I certify that the information given by me in applying of payment under Title XVIII and Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf.

VI. **TOBACCO USE POLICY**
NorthCrest Physician Services is a tobacco free facility. I understand that while I am a patient at NorthCrest Physician Services I may not use tobacco products.

I hereby certify and state that I have read, and that I fully and completely understand the above Conditions of Admission and Authorization for Medical Treatment, and that I have signed this Conditions of Admission and Authorization for Medical Treatment knowingly, freely, and voluntarily.

____ __________________

Signature of Patient / Parent / Guardian / Conservator Date