Patient Information Form

George K. Aitken, M.D.
Orthopedic Surgeon

PATIENT NAME: ______________________ BIRTH DATE: __________ AGE: ______

ADDRESS: ______________________ CITY/STATE/ZIP: ______________________

PHONE: (HOME) ______________ (WORK) ______________ (MOBILE) ______________

SOCIAL SECURITY #: ______________ SEX: M / F (circle) MARITAL STATUS: __________

EMAIL ADDRESS: ______________________ LIST HOBBIES/SPORTS: ______________

OCCUPATION: ______________ EMPLOYER: ______________ RETIRED: Y / N (circle)

HOW DID YOU HEAR ABOUT US? ______________________________

WHAT IS THE PROBLEM / COMPLAINTYOU ARE HAVING TODAY? ______________________

NAME OF FRIEND OR RELATIVE (Not living with you): ______________ PHONE: __________

HAVE YOU EVER TAKEN CORTISONE OR PREDNISONE? ______ HAVE YOU EVER HAD A BLOOD TRANSFUSION? ______

HAVE YOU EVER HAD: JAUNDICE ______ HEPATITIS ______ SEIZURES ______ CONVULSIONS ______

IF YES, PLEASE EXPLAIN ______________________________

HAVE YOU EVER HAD A REACTION OR COMPLICATION WITH GENERAL OR LOCAL ANESTHESIA? ______

IF YES, PLEASE EXPLAIN ______________________________

NOTICE OF ORTHOPEDIC BRACE POLICY

The below statement is for your information only. Not all **ORTHOPEDIC BRACES** are covered by insurance. We will let you know during your visit today if Dr. Aitken feels a brace is medically necessary. IF your insurance does not cover this expense, **YOU WILL BE FINANCIALLY RESPONSIBLE** for the cost.

Please sign below to acknowledge that you understand and agree to comply with the above statements.

PATIENT SIGNATURE: ______________________________ TODAY'S DATE: __________

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Injury Form

PATIENT NAME: ____

If you are *NOT* here Today because of an *Accident or Injury*, Please tell us where you are having pain (then sign your name at the bottom of this page): ____

____

Is your visit today due to an accident or injury? _______ yes _______ no

If yes, please explain: ____

____

Date of Injury: ____________________ Time of Injury: ____________________ am/pm

Did *Accident or Injury* occur at home? ____________________ If you answered no, where did *Accident or Injury* occur? ____

Place of accident or injury: City: ____________________ State: ____________________

Is this *Accident or Injury* related to your employment? ____________ If yes, please explain: ____________

____

Did you file a worker's compensation claim? ____________ If yes, *please give receptionist all necessary information including worker's comp carrier, your claim number, etc.*

Is this *Accident or Injury* related to a car accident? ____________ If yes, please explain: ____________

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Please give receptionist all pertinent car insurance information.

PATIENT SIGNATURE: ____ DATE: ____________

(If 18 years of age or older)

SIGNATURE: OF PARENT OT GAURDIAN: ______________________________ DATE: ____________

(If patient is under 18 years of age)

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SIGNATURE ON FILE

- ✓ I authorize the use of this form on all of my insurance submissions.
- ✓ I authorize release of medical information to my insurance companies.
- ✓ I understand that I am responsible for all fee's regardless of my insurance coverage.
- ✓ I understand that there may be services that are provided to me by Dr. Aitken that are not covered by my insurance and I agree to be financially responsible for such services. I also understand that all fee's (including Co-Pay amounts) are to be paid at the time of service unless arrangements have been made prior with the Billing Manager.
- ✓ I authorize my doctor to act as my agent in helping obtain payment from my insurance carrier(s).
- ✓ I authorize payment directly to Dr. Aitken.
- ✓ I permit a copy of this authorization to be used in place of the original.

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare Benefits be made on my behalf to George K. Aitken, M.D., P.S.C. for any services furnished by Dr. Aitken. I authorize any holder of medical information about me to release to HCFA, CMS and it's agents any information needed to determine benefits payable for services rendered. I understand that my signature requests that payment be made to Dr. Aitken for services. If other health insurance is indicated, my signature authorizes release of the information to the insurer or agency. George K. Aitken, M.D., P.S.C. agrees to accept the charge/payment determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance amount and non-covered services.

DISCLOSURE OF MY MEDICAL/HEALTHCARE INFORMATION

I authorize the physician or designated staff members of George K. Aitken, M.D., P.S.C. to discuss my medical and healthcare information and treatment with the following individuals on my behalf:

NAME:______________________________RELATIONSHIP:____________________ PHONE:__________________

NAME:______________________________RELATIONSHIP:____________________ PHONE:__________________

NAME:______________________________RELATIONSHIP:____________________ PHONE:__________________

Our usual method of contacting you will be by phone. Unless you specify otherwise, we will leave a detailed message on your answering machine or voicemail or with one of the persons listed above, should you be unavailable at the time of our call.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of George K. Aitken, M.D., P.S.C.'s Notice of Privacy Practices detailing how my information may be used and disclosed as permitted under Federal and State law. I am aware that I may request the following restriction(s) concerning my personal medical information: _________________________

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Patient's Signature _______________________________________ Date ____________________________