Patient Name: _____ **Date:** _____

Pharmacy: _____ **Pharmacy phone #:** _____

Emergency Contact: _____ **Emergency Contact phone #:** _____

Employer: _____

HIPAA Authorization Form for Family Members/Friends

I, _____, give permission to **The Orthopedic Group** to disclose and release my protected health information described below to:

Name:	Relationship:	Phone #:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health Information to be disclosed (Initial):

___ My complete health record (including by not limited to; diagnoses, lab tests, treatment, medications, mental health, communicable diseases, drug/alcohol information, and billing)

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.
This authorization shall be effective until I revoke it by notifying The Orthopedic Group, in writing, of any changes.

CONSENT TO OBTAIN MEDICAL HISTORY

I authorize The Orthopedic Group to electronically obtain records of medication prescribed for me by other physicians/providers.

AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (print name), hereby acknowledge that on the date set forth below, I have received The Orthopedic Groups, P.C.'s Notice of Privacy Practices, upon request.

_____
Printed name of the individual giving this Authorization

_____ _____
Signature of the individual giving this Authorization Date

Name or parent/guardian if patient is a Minor: _____

PLEASE READ, SIGN, AND DATE:

I request that payment of authorized Medicare/other insurance benefits be made on my behalf to THE ORTHOPEDIC GROUP, PC for any services furnished me by physician or supplier. I authorize the release of my medical information to the Centers for Medicare & Medicaid Services and/or my insurance company and its agents; any information needed to determine these benefits/benefits payable for related services. I am responsible for all charges regardless of insurance status, as well as co-payments and deductibles.

SIGNATURE: _____ DATE: _____

What is the reason for today's visit?_____

_____

What are your current symptoms? _____

Precipitating Event?_____ When?_____

Pain at worst on 0-10 Scale_____ Least pain on 0-10 Scale_____

What makes your pain better?_____ What makes it worse?_____

Have you been seen by another physician or therapist for this problem?

NO _____ If YES by whom? _____

Review of systems:
Circle if you have: Fever, Chills, Night sweats, Vision changes, Rashes, Weakness
Chest pain, Shortness of breath, Depression, Anxiety, Swelling in arms or legs
Headache, Numbness, Tingling, Bowel or Bladder changes, Recent weight gain or loss,
Excessive Bruising, Hearing Problems, Heartburn, Constipation, Diarrhea, Seizures, Joint Pain
None of the above

PAIN INTENSITY RATING

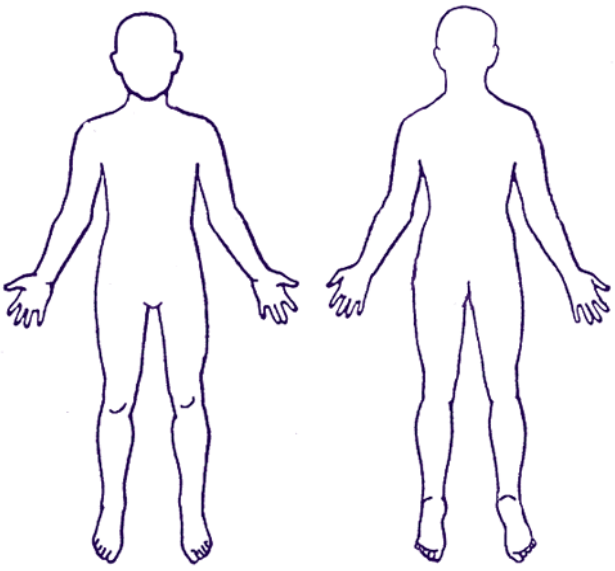
On the line below, CIRCLE your AVERAGE PAIN over this last week

No Pain Worst Possible
0 1 2 3 4 5 6 7 8 9 10

Where is your pain now?

Use appropriate symbols shown below to mark the areas on your body where you feel the described sensations.
Include ALL areas affected by your pain and mark the type and area of pain if it radiates or spreads to other areas.

BURNING XXXX	NUMBNESS OOOO	PINS & NEEDLES	STABBING	ACHE



FRONT BACK

The Orthopedic Group, PC **Today's Date:**

Name:_____ Date of Birth:_____

PAST MEDICAL HISTORY

Conditions	Treatment

MEDICATIONS: Please list any medications you are currently taking, including vitamins and herbal supplements:

Medication	Dosage/Frequency	Reason for Medication	Date Medication Started	Who Prescribed Medication?

HAVE YOU EVER TAKEN ANY TYPE OF ANTI-INFLAMMATORY MEDICATION? YES NO
If YES, Please list the medication, when taken, why taken, and any complications or side-effects:

ALLERGIES: Please list any medications you are allergic to:

_____
_____

SOCIAL HISTORY:

Question	YES	NO	What type?	If yes, how much?	If stopped using, when & how much?
Do you use tobacco in any form?					
Do you drink alcohol?					
Do you have a history of substance abuse?					

FAMILY HISTORY:
What diseases or conditions exist in your immediate family? (mother, father, sister, brother)

_____
_____

Does anyone in your family have cancer?

_____
_____