

HEADWATERS ORTHOPEDICS, P.L.C.

PLEASE FILL IN ALL OF THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

PARENT'S NAME (IF CHILD) \_\_\_\_\_

PATIENT'S SOCIAL SECURITY # \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_

NAME OF PERSON RESPONSIBLE FOR BILL: \_\_\_\_\_  
(IF OTHER THAN SELF)

ADDRESS: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

PATIENT'S EMPLOYER: \_\_\_\_\_  
(OR PARENT'S EMPLOYER, IF MINOR)

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

SPOUSE'S EMPLOYER: \_\_\_\_\_ SPOUSE'S DOB: \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME OF PERSON TO NOTIFY IN EMERGENCY:  
OTHER THAN IMMEDIATE HOUSEHOLD \_\_\_\_\_ PHONE: \_\_\_\_\_

IS THIS A WORKERS COMPENSATION CLAIM      YES \_\_\_\_\_      NO \_\_\_\_\_      HEALTH INSURANCE COMPANY: \_\_\_\_\_

POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURED NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

MEDICARE # \_\_\_\_\_

MEDICAID # \_\_\_\_\_

NAME OF FAMILY PHYSICIAN \_\_\_\_\_ REFERRED BY \_\_\_\_\_

REASON FOR THIS VISIT: \_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_

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**SPACE BELOW FOR OFFICE USE ONLY**

VERIFIED BY: \_\_\_\_\_

INSURANCE CARRIER: \_\_\_\_\_ POLICY # \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ATTENTION: \_\_\_\_\_

**PLEASE COMPLETE OTHER SIDE**

**HEALTH HISTORY**

AGE: \_\_\_\_\_

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?      PLEASE INDICATE WITH A CHECK.

Any heart problems	_____	Allergies to anesthetics	_____	Cancer	_____
High Blood Pressure	_____	Allergies to _____	_____	Measles	_____
Low Blood Pressure	_____	HIV	_____	Mumps	_____
Circulatory problems	_____	Anemia	_____	Psychiatric care	_____
Nervous problems	_____	Arthritis	_____	Rheumatic Fever	_____
Radiation treatments	_____	Asthma	_____	Kidney disease	_____
Excessive bleeding	_____	Diabetes	_____	Scarlet fever	_____
Pacemaker	_____	Hepatitis	_____	Sinus problems	_____
Stroke	_____	Typhoid fever	_____	Tonsilitis	_____
Tuberculosis	_____	Ulcer	_____	OTHER _____	_____

ARE YOU TAKING ANY TYPE OF MEDICATION NOW? \_\_\_\_\_

FOR WHAT PURPOSE? \_\_\_\_\_

HAVE YOU HAD ANY SERIOUS ILLNESS OR OPERATION IN THE LAST FIVE (5) YEARS? \_\_\_\_\_

ARE YOU PREGNANT? \_\_\_\_\_

PLEASE DESCRIBE ANY CURRENT TREATMENT, IMPENDING OPERATIONS, OR ANY OTHER MEDICAL INFORMATION THAT YOU FEEL I SHOULD KNOW ABOUT: \_\_\_\_\_

**GENERAL RELEASE OF INFORMATION AND PERMISSION TO TREAT**

I hereby authorize HEADWATERS ORTHOPEDICS, P.L.C., to release information regarding my care to my insurance company and to other physicians involved in my case I hereby give permission to the physicians and staff of HEADWATERS ORTHOPEDICS, P.L.C. to examine and treat my medical condition.

Due to increased costs of mailing statements and in trying to keep our fees as low as possible, we find it necessary to expect our patients to pay for services at the time they are rendered, unless prior arrangements have been made by our receptionist/business assistant. Until arrangements are made we will expect payment each time we see you. We want to give you the best and most reasonable service possible without having to raise our fees and will appreciate your cooperation in this matter.

I FULLY UNDERSTAND AND AGREE TO THE ABOVE POLICIES AND AUTHORIZATIONS.

\_\_\_\_\_  
SIGNATURE OF PATIENT  
(PARENT IF PATIENT IS A MINOR)

\_\_\_\_\_  
DATE

**METHOD OF PAYMENT:**  
CASH \_\_\_\_\_ CHECK \_\_\_\_\_  
M/C \_\_\_\_\_ VISA \_\_\_\_\_  
DISCOVER \_\_\_\_\_

**FOR WORKERS COMPENSATION PATIENTS ONLY:**

This is to authorize HEADWATERS ORTHOPEDICS, P.L.C. to release any information regarding my care in this case to my employer's insurance carrier. Also, I authorize payment of medical benefits to HEADWATERS ORTHOPEDICS, P.L.C.

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE

