ALL AMERICAN ORTHOPEDIC AND SPORTS MEDICINE INSTITUTE

Patient Information							
Name						D. O. B.	
Address						Sex	M / F
City		State		Zip		Marital Status	M / S / W / D
Cell No.		Home No.				S.S. No.	
Email						D.L. No.	
Race		Ethnicity				Language	
Employer						Work Phone No.	
Occupation							
Emergency Contact/ Relationship to PT				Phone No.			
Primary Care Physician				Phone No.			
Referred By			If student, your school?				
Pharmacy			Pharmacy Address				

THE INFORMATION NEEDED BELOW IS THE ACTUAL CARD HOLDER'S INFORMATION.
IF THE PATIENT IS UNDER 18, WE NEED PARENT OR GUARDIAN INFORMATION.

Insurance details							
Insured's name						D. O. B.	
Relationship to Patient						Home No.	
D.L. No.		S.S. No.				Cell No.	
Employer Name				Work No.			
Primary Insurance Company						Phone	
Address						Insured's ID	
City		State		Zip		Group No.	
Secondary Insurance Company						Phone	
Address						Insured's ID	
City		State		Zip		Group No.	

I, BEING OF LEGAL AGE (18 OR OLDER), UNDERSTAND THAT I AM RESPONSIBLE FOR ALL ACCOUNTS WITH *ALL AMERICAN ORTHOPEDIC AND SPORTS MEDICINE INSTITUTE*.
I AUTORIZE RELEASE OF INFORMATION TO MY INSURANCE COMPANY.

X _____ Patient / Parent / Guardian Signature

_____ / / Date

Patient name_____ DOB _____ Date _____

Today's complaint: _____
Circle: RT LT Bilateral
Have you had any treatment, scans, x-rays, surgeries for this condition?
If yes, when and where? _____
Did you bring the x-rays, disc, and report? _____

Height _____ **weight** _____
Medications (all currently taking)

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____
_____

Allergies to medications Reaction

_____ _____ _____ _____
_____ _____ _____ _____

For insurance purposes:
How did your injury occur? _____
Is your injury due to an accident? _____ date _____ time _____
School related? _____ work related? _____
Name of any other party involved _____
How long have you had this pain? _____
Did you go to the ER? _____when/which one? _____

Occupation _____ lifting/climbing? _____

Social History
Exercise _____recreational activities _____
Lifestyle/recent changes _____
Education _____ schools attended _____
Diet _____ sports _____
Dominant hand _____right _____left dominate foot ____right _____left

Privacy Notice Agreement

I have received the Privacy Notice and have been given the opportunity to review its contents.

Signature: _____

Date : _____

Medical Consent Form for All American Orthopedic and Sports Medicine Institute

Patient Name: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize to furnish any consulting physician, hospital, physical therapy facility, MRI facility, and/or medical supplies facility and their representatives, any information or copies of all medical records, consultations, and prescriptions relating to my illness or injury. I authorize All American Orthopedic and Sports Medicine Institute and/or staff to furnish medical records relating to my illness or injury to the contracted billing company, Medical Insurance Processors, to file appropriate medical information to my insurance company for reimbursement. A copy of this authorization shall be in effect and valid until rescinded in writing._____ (initial)

AUTHORIZATION OF INSURANCE BENEFIT PAYMENTS

I authorize direct payment of medical benefits through my insurance carrier of worker's compensation carrier for services rendered. **I understand that I will be billed and held responsible for any balance insurance does not pay. I understand that office deductibles, percentages, and/or co-pays are due and payable at the time of my office visit**. I understand that if my condition requires surgical intervention, my insurance company will be contacted for eligibility and precertification. If the representative for All American Orthopedic and Sports Medicine Institute is advised by my insurance company that I will be responsible for a percentage of the fee, I understand that I will be asked to pay this portion prior to my surgery. _____ (initial)

CONSENT FOR MEDICAL TREATMENT

I, knowing that I am suffering from a condition requiring diagnostic, medical, or surgical treatment do hereby voluntarily consent to such procedures and care under the specific instructions of All American Orthopedic and Sports Medicine Institute, and/or their representatives. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of treatments or examination by All American Orthopedic and Sports Medicine Institute. I acknowledge that X-ray films will be taken for my condition at the time of my visit and these will be viewed by the All American Orthopedic and Sports Medicine Institute physician at his workstation. Upon completion of my visit with All American Orthopedic and Sports Medicine Institute, a verbal dictation will be made by the All American Orthopedic and Sports Medicine Institute physician at his workstation. _____ (initial)

CONSENT FOR RELEASE OF MEDICAL INFORMATION TO FAMILY MEMBERS AND/OR SCHOOL PERSONNEL

I authorize All American Orthopedic and Sports Medicine Institute and/or staff to relay medical information to:
spouse_____ stepparents (if minor) _____ family member _____
school staff_____ coaches, physical trainers, school administration personnel_____

CONSENT TO LEAVE MESSAGES

I authorize All American Orthopedic and Sports Medicine Institute, and/or staff, to leave necessary messages and appointment reminders at my home or place of employment. _____ (initial)

I authorize All American Orthopedic and Sports Medicine Institute and/or staff to use MRI's or X-rays for research and/or teaching purposes only. _____ (initial)

MEDICAL TRAINING

All American Orthopedic and Sports Medicine Institute is a teaching facility for medical professionals. At times we may have interns, residents, fellows, or medical/chiropractic students and allied arts students, rotating through our offices. These students follow the same rules of confidentiality and professionalism as do all of our medical professionals. You are free to decline having a student or medical trainee in your office consultation by informing your nurse or physician.