PERIODIC HISTORY AND PHYSICAL

Patients Name:_____ Today's date_____

Date of birth_____ Age_____ Sex: Male/ Female

____ Married ____ Divorced ____ Separated ____Single ____ Widowed

Reason for today's visit_____

If accident, describe_____

Date of injury_____ Circle: Right handed/ Left handed

Occupation:_____

Pharmacy Name & Number:_____

MEDICINE (s)- List all medication, birth control pills, or vitamins you take with or without a prescription:

MEDICATION	DOSAGE	FREQUENCY

MEDICATION ALLERGY– List all medications that you are *allergic* and/or sensitive to:

_____

ILLNESS: If you have had any of the following, make the appropriate line.

___Alcoholism	____Blood clots	____Heart attack/disease	____Osteoporosis	____Thyroid disease
___Anemia	____Blood transfusion	____Hepatitis	____Phlebitis	____Cancer, Tumor
___Arthritis	____Diabetes	____High blood pressure	____Seizures,	____Ulcer in stomach
___Asthma	____Drug abuse	____Liver disease, jaundice	epilepsy	duodenum
___Bleeds easily	____Depression	____Lung disease	____Skin condition	

Do any family members have any of the above? If so, what?_____
_____
_____

Any prior fractures? Yes/ No. If yes, describe_____
Any tingling or numbness in arms or legs?_____
Any bowel or bladder complaints?_____
Any recent chills, fever, or night sweats?_____
Any unexplained weight loss?_____
Any pregnancies? (If applicable)_____

HOSPITALIZATIONS/ SURGERY-List illness or operation(s), and approximate year:

19____ _____	20____ _____
19____ _____	20____ _____
20____ _____	20____ _____

Acct#: _____ Date: _____

Patient: _____ Date of Injury: _____

Address: _____ Employer: _____

_____ Address: _____

Home Telephone: _____ _____

Cell Phone: _____ Business Telephone: _____

Age: _____ Date of Birth: _____/_____/_____ Male: _____ Female: _____

Marital Status: S _____ M_____ W_____ D_____ Social Security #: _____

Primary Care Physician: _____ Office Telephone: _____

Contact Person _____ Telephone _____

MEDICAL INSURANCE	CERTIFICATE NUMBER	SUBSCRIBER	RELATIONSHIP
MEDICARE			
MEDEX			
BLUE CROSS/BLUE SHIELD			
HMO: Name:_____			
MASS HEALTH			
OTHER HEALTH INSURANCE: _____			
ADDRESS OF INSURANCE: _____			

WORKER'S COMPENSATION / AUTOMOBILE ACCIDENT

Insurance Carrier: _____

Address: _____ Tel #: _____

Claim/File #: _____ Date of Injury: _____

EXTENDED AUTHORIZATION AND CONSENT

I request that payments of medical benefits be made directly to the physician on any unpaid bills for services rendered to me on or after_____.

I further authorize the release of any medical information necessary to process this or related claims. I also request payment of government benefits to the party who accepts assignment. I permit a copy of this authorization to be used in place of the original.

Signed: _____ Date: _____

O'CONNOR ASSOCIATES

PLEASE READ – YOUR SIGNATURE IS REQUIRED

VERY IMPORTANT INFORMATION REGARDING YOUR
INSURANCE AND PRIVACY PRACTICES POLICYIES AND PROCEDUES.

At each office visit we require your referral and insurance information. This is for your protection. **Without a referral from your insurer, you are responsible for services and/or diagnostic tests. Any non-covered services are your responsibility.**

It is **your** responsibility to provide us with the correct insurance information at the time of service. If there is a problem with your claim, and we do not have a copy of your current insurance card, the balance will become **your** responsibility.

Co-payments are due at the time of service. Any co-payments not paid at this time will incur a $10.00 service charge.

If you **no-show** your scheduled appointment, you may **or** may not be charged a $35.00 no-show fee, at providers discretion.

If this visit is related to an automobile accident, referrals from your health insurance and co-pays if applicable **are still required**.

Thank you,

Merrimack Valley Orthopaedic Associates, LLC.

Your signature below indicates that you have reviewed a brochure of HIPPA (Health Insurance Probability and Accountability Act of 1996) and have read and understand all of the about information.

Printed Name: _____DOB_____

Signature: _____Date_____

If you would like a brochure, please ask one of the receptionists up front.