

Comprehensive History

Past, Social, and Family History



Date: ____ / ____ / ____

Patient Name: _____ Date of birth: ____ / ____ / ____

Height: _____ Weight: _____ Age: _____ Right or Left Handed: Right Left

What problems are you here for today? _____ _____ _____ _____	Latex Allergy?: <input type="checkbox"/> Yes <input type="checkbox"/> No List any allergies to medications: _____ _____ _____
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Past Medical History:

1. Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain.

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease / Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Lung problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder/Blood Clot	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Stomach or intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems / stones	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

2. Please list any current medications (and amounts, times per day):
(include aspirin, antacids, anti-inflammatories, hormone replacement, birth control, allergy meds):

3. Please list any operations (and date) you have ever had (including tonsils and adenoids):

Social History:

Marital Status: Single Married Divorced Widowed

Education Status - Highest Level: Less than High School High School College Graduate

	Yes	No	
Do you smoke? List how much.	<input type="checkbox"/>	<input type="checkbox"/>	_____
If no, did you smoke previously?	<input type="checkbox"/>	<input type="checkbox"/>	_____
How often do you drink alcohol?			_____
History of drug addiction?	<input type="checkbox"/>	<input type="checkbox"/>	_____
What is your occupation?			_____

Family History:

Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses.
 If yes, please indicate which relative(s) have the problem.

	Yes	No	Father	Mother	Siblings	Grandparents
Heart problems / murmurs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Allergy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Anesthesia problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____



GREAT FALLS ORTHOPEDIC ASSOCIATES

OUR OFFICE POLICY

Patient Name: _____ Date of Birth: _____

BASIC POLICY Payment for service is due in full at the time service is provided in our office, unless prior payment arrangements have been discussed with a Financial Counselor.

COMMERCIAL INSURANCE POLICY We will bill most insurance carriers for you. **Complete insurance information and a copy of your insurance card(s) must be provided prior to services.** Co-pays and deductibles must be paid at the time of service. Because we may not be networked with your insurance, you may be billed for any balance over and above your co-pay. Although we research denied claims and appeal denials, if appropriate, you may ultimately be responsible for services not covered by your insurance. If an insurance carrier has not paid within 60 days of billings, professional fees are due and payable in full from you.

TRICARE PRIME and ACTIVE DUTY POLICY You must obtain prior authorization form your Primary Care Provider.

HMO INSURANCES It is your responsibility to obtain prior authorization from your Primary Care Provider prior to services. You must also provide our office with the name and address of your Primary Care Provider.

MEDICARE POLICY We are participating providers for Medicare, however you are responsible for the 20% co-insurance and any deductibles that may apply. We will bill secondary insurances for you, but you will still be responsible for any reduction taken by your secondary insurance up to the 20% allowed by Medicare.

MEDICARE ADVANTAGE PLANS (HUMANA, STERLING OPT I OR II, ETC.) Your co-pay for the office visit will be collected at the time of service. Medicare Advantage Plans will also charge you a co-pay on other services provided such as x-rays and injections, so you may be billed for these balances, in addition to your office visit co-pay.

MEDICAID POLICY We do bill Medicaid for you. You are responsible to obtain a referral from your Primary Care Provider prior to services. Co-pays are due and payable prior to services. If your Primary Care Provider denies authorization, you will be responsible for payment.

SURGERY POLICY All co-pays, deductibles and payments for non-covered surgical are due prior to your surgery. Prior authorization may be required by your insurance. **Uninsured patients require 100% pre-pay for non-emergency surgery.**

NON-COVERED SERVICES Any services or supplies deemed non-covered or not a benefit of your plan will require payment in full upon notice of insurance denial.

AUTO/THIRD PARTY LIABILITY We will need complete billing information, including claim number, insurance carrier, date of injury, and attorney information, if applicable. If information is incomplete, you will be considered self-pay.

WORKERS COMPENSATION POLICY We will need a copy of the notice of injury from your employer, the case number and carrier name prior to your visit. If information is not complete, you will be considered self-pay.

PLEASE CHECK ONE: I HAVE PAID MY INSURANCE DEDUCTIBLE OR PREMIUM FOR THE CALENDAR YEAR. YES NO DON'T KNOW

CONSENT FOR TREATMENT AND LIFETIME AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby give consent to GREAT FALLS ORTHOPEDIC ASSOCIATES to provide whatever treatment they deem necessary to the patient.

I certify that the information I furnish is true and correct. I am fully aware that it is a felony to falsify any information relating to my medical condition.

I hereby authorize GREAT FALLS ORTHOPEDIC ASSOCIATES to submit a claim to my insurance carrier, or its intermediaries for all covered services rendered by the physician(s). I also authorize my insurance carrier, or its intermediaries to issue payment directly to the physician(s). A photocopy of this assignment is considered to be as valid as an original.

I hereby authorize GREAT FALLS ORTHOPEDIC ASSOCIATES to furnish complete information requested by my insurance carrier, or its intermediaries regarding services rendered.

I further agree that I am responsible for payment of any remaining balance after insurance payments have been made, including any collection costs or legal fees incurred to collect these balances.

SIGNATURE OF PATIENT: _____ DATE: _____