NEBRASKA ORTHOPAEDIC AND SPORTS MEDICINE, PC

575 South 70th Street
Suite 200
Saint Elizabeth Medical Plaza
Lincoln, Nebraska 68510-2471

Toll-Free (888) 488-6667
(402) 488-3322
Fax (402) 488-1172
www.nebraskaortho.com

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Donald J. Walla, M.D.
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Daniel R. Ripa, M.D.

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Patient Demographics and History Form

Today's Date _____

Name _____
First: Middle: Last:

Gender □ Male □ Female **Date of Birth** (mm/dd/yyyy) _____ **Social Security #** _____

Height _____ **Weight** _____ **Preferred Pharmacy/Location** _____

Address _____

City _____ **State** _____ **Zip** _____

Home Phone # _____ **Cell #** _____ **Work #** _____

E-mail Address _____
(please enter legal guardian's email if patient is under the age of 19)

Race □ American Indian / Alaska Native □ Asian □ Black / African American □ Nat Hawaiian / Pacific Islander
□ White □ Declined □ Other Race: _____

Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino □ Declined

Military/Veteran Status: Have you ever served or are you currently serving in any branch of the US military? □ Yes □ No

Employment Status □ Employed □ Student □ Retired □ Unemployed □ Other _____

Employer Name _____ Occupation _____

Student: School Name _____

Primary Language Spoken

□ English □ Spanish □ French □ German □ Russian □ Italian
□ Japanese □ Korean □ Chinese □ Vietnamese □ Farsi □ Tagalog
□ Other: _____

Primary Insurance

Primary Insurance Company _____

Policy ID Number _____ Policy Group Number _____

Is the Patient the policy holder? □ Yes □ No If no- Relationship to Primary Policy Holder _____

Name of Primary Policy Holder _____

Date of Birth of Primary Policy Holder _____ Gender: □ Male □ Female

Policy Holder's Social Security Number _____

Street Address of Primary Policy Holder _____

City _____ State _____ Zip Code _____

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Secondary Insurance (if applicable)

Primary Insurance Company _____

Policy ID Number _____ Policy Group Number _____

Is the Patient the policy holder? □ Yes □ No If no- Relationship to Primary Policy Holder _____

Name of Primary Policy Holder _____

Date of Birth of Primary Policy Holder _____ Gender: □ Male □ Female

Policy Holder's Social Security Number _____

Street Address of Primary Policy Holder _____

City _____ State _____ Zip Code _____

Worker's Compensation / Liability Confirmation □ No □ Yes **If Yes, complete the following:**

Date of Injury _____ Injured Body Part(s) _____

Worker's Compensation Employer _____

Worker's Compensation Contact Person at Employer _____

Worker's Compensation Employer Phone Number _____

Worker's Compensation / Liability Insurance _____

Worker's Compensation / Liability Insurance Phone _____

Worker's Compensation / Liability Claim Address _____

City _____ State _____ Zip Code _____

Worker's Compensation / Liability Claim Number _____

Worker's Compensation / Liability Insurance Adjuster _____

Marital Status □ Single □ Married □ Divorced □ Separated □ Widowed

Spouse Information (if applicable)

Spouse Name _____

Spouse Date of Birth _____ Spouse Social Security _____

Parent / Guardian Demographics (if patient is under 19)

Name _____

Date of Birth _____ SSN _____

Primary Phone _____ Cell Phone _____

Address (if different than above) _____

City _____ State _____ Zip Code _____

Emergency / Medical Contact Emergency

Contact Name _____

Contact Phone Number _____ Relationship: _____

Referral Source / Primary Care Physician

Primary Care Physician _____

Referring Physician _____

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Chief Complaint Chief

Body Part _____ Date of Injury _____

Occurred

□ Car Accident □ Fall □ Gradual Onset □ Sports / Recreational Injury

□ Unknown □ Other _____

Pain Scale (*please circle one on a scale of 1-10*)

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

Treatments / Tests since onset symptoms □ None

□ Steroid Injection □ CT Scan / MRI □ Medication □ Physical Therapy

□ Surgery □ X-Ray □ Other / Not Listed _____

Past Medical History

□ Right handed □ Left handed

Past and Current Medical Conditions □ None

□ Abnormal Heart Rhythm	□ Alcoholism	□ Anemia	□ Anorexia Bulimia
□ Anxiety	□ Asthma	□ Bleeding Disorders	□ Blood Clots / DVT
□ Bronchitis	□ Cancer	□ Depression	□ Diabetes
□ Emphysema	□ Endometriosis	□ Gout	□ Heart Attack
□ Heart Failure	□ Hepatitis	□ High Blood Pressure	□ HIV
□ Irritable Bowel	□ Kidney Failure	□ Kidney Stones	□ Liver Disease
□ Lung Disease	□ Osteoarthritis	□ Osteoporosis	□ Ovarian Cysts
□ Rheumatoid Arthritis	□ Seizures	□ Sleep Apnea	□ Stents
□ Stomach Ulcers	□ Stroke	□ Thyroid Disease	□ Tuberculosis
□ Other_____			

Medications □ No Medications

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

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Drug Allergies □ No Drug Allergies

□ Anti-seizure Medications □ Aspirin □ Codeine Phosphate □ Codeine Sulfate
□ Contrast Dye □ Demerol □ Depakote □ Dilantin
□ Insulin □ Iodine □ Latex □ Morphine
□ Penicillin □ Sulfa □ Other (List Below)

Other Drug Allergies

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Surgeries or Procedures □ No Surgeries

□ Angioplasty □ Appendectomy □ Back Surgery □ Cardiac Stent / Catheterization
□ Cataract Surgery □ Cesarean Section □ Colon / Bowel Surgery □ Gastric Bypass
□ Hernia Repair □ Hysterectomy □ Joint Replacement □ Kidney Surgery
□ Neurosurgery □ Pacemaker Implantation □ Problems with Anesthesia in the Past □ Thyroid Surgery / Biopsy
□ Other/Not Listed - (List below)

Surgeries or Procedures Other

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Family Medical History □ No Family History

Cancer	□ Father	□ Mother	□ Brother	□ Sister
Diabetes	□ Father	□ Mother	□ Brother	□ Sister
Heart Disease	□ Father	□ Mother	□ Brother	□ Sister
Stroke	□ Father	□ Mother	□ Brother	□ Sister

□ Other _____

Social History Smoking Status □ Current everyday □ Current some day □ Former □ Never

Alcohol Status □ Current everyday □ Current some day □ Former □ Never

Exercise □ No Exercise □ Heavy amount of exercise *(4 or more times per week)* □ Moderate amount of exercise *(1-3 times a week)* □ Minimal amount of exercise *(1 time a week)* □ Active but no formal exercise

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Receipt of Notice of Privacy Practices

I acknowledge that I was notified there were changes made to the Notice of Privacy Practices. I was given the opportunity to receive a copy of Nebraska Orthopaedic and Sports Medicine, P.C. Notice of Privacy Practices which are effective April 11, 2013. I understand that the Notice describes the uses and disclosures of my protected health information and informs me of my rights with respect to my protected health information.

_____ _____

Date Printed Name

_____

Signature (must be signed by parent/legal guardian if patient is a minor)

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Authorization to Release Information & Pay Benefits to Physician

I hereby authorize NEBRASKA ORTHOPAEDIC & SPORTS MEDICINE, P.C. to file claims and release any medical information necessary to process this claim for insurance or for Worker's Compensation benefits. I hereby authorize payments directly to NEBRASKA ORTHOPAEDIC & SPORTS MEDICINE, P.C. for the surgical and/or medical benefits, if any, otherwise payable to me for the services. I understand that I am financially responsible for the charges not covered by this authorization or insurance.

Unless other arrangements have been made and agreed to by the parties in writing, the amount due as reflected on a statement is due when services are rendered. A late payment charge of one and one-third percent (1 1/3%) per month shall be charged on any unpaid amounts from and after the 61st day following the date the patient's financial responsibility is determined.

I understand and agree that any cellular or land line phone numbers and email addresses provided by myself to this office and to any of our services providers, including but not limited to, third party debt collectors, now and in the future, may be used as a means to contact me for any reason, including but not limited to, billing and collecting payment, and that this office and our service providers may leave messages for me manually and by using automatic systems such as by artificial or prerecorded voice. I also agree that this office and any service providers may contact me by sending text messages and emails to any phone number or email address I provide to this office or service providers and I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communications. In the future, should I acquire a new or different cellular, landline or email address, I agree that this consent would stay effective.

_____ _____

Date Signature (must be signed by parent/legal guardian if patient is a minor)

I hereby authorize Nebraska Orthopaedic & Sports Medicine, PC to appeal all claims for charges I will incur as a patient of this facility.

_____ _____

Date Signature (must be signed by parent/legal guardian if patient is a minor)

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CONSENT TO RELEASE MEDICAL AND BILLING INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

The Health Insurance Portability and Accountability Act of 1996, as amended, (HIPAA), allows your healthcare provider or staff of Nebraska Orthopaedic and Sports Medicine, P.C. (Practice) to discuss your medical or billing information with members of your family or other individuals involved in your medical care upon your approval, or when given the opportunity, you do not object, or when your healthcare provider reasonably infers from the circumstances, based on his/her professional judgment, that you do not object to such disclosure. To assist our Practice in determining your desires with respect to such disclosures, we ask that you complete this form. You may revoke or modify this consent at anytime by submitting a revised form.

_____I **do not** authorize Practice to disclose any information concerning my medical care and billing information to family members, other relatives, personal friends or any other person; provided, however, in the event I am incapacitated or there is an emergency situation, my healthcare provider may disclose my medical and billing information, whether in person, over the phone or in writing, that is directly relevant to those involved in my medical care, if the healthcare provider, based on his/her professional judgment, determines the disclosure is in my best interests.

_____I **authorize** Practice to disclose, to the following individuals, medical care and billing information, whether in person, over the phone or in writing, directly relevant to such individual's involvement with my medical care or payment related to my medical care; provided, however, in the event I am incapacitated or there is an emergency situation, my healthcare provider may disclose my medical and billing information, whether in person, over the phone or in writing, that is directly relevant to those involved in my medical care, even though their name does not appear below, if the healthcare provider, based on his/her professional judgment, determines the disclosure is in my best interests.

_____ Name	_____ Relationship to Patient
_____ Name	_____ Relationship to Patient
_____ Name	_____ Relationship to Patient
_____ Name	_____ Relationship to Patient
_____ Print Patient Name	_____ Date of Birth
_____ Patient Signature	_____ Date
_____ Patient Account Number	

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Pharmacy Benefit Management (PBM) Consent Form

Electronic Prescribing (eRx)

E-Prescribing - is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Medication History Transactions – Provides the physician with information about medications that the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent you are agreeing that Nebraska Orthopaedic and Sports Medicine, P.C. can request and use your prescription medication history from other healthcare providers and/ or third party pharmacy benefit payors for treatment purposes.

_____ _____

Date Printed Name

_____

Signature (must be signed by parent/legal guardian if patient is a minor)