BOWLING ORTHOPAEDICS, P.A.
STOP PAIN. GET BACK TO LIFE

PATIENT REGISTRATION

Date:_______________

Patient's Name: Last: _______________________ First: ___________________ Middle Initial:_______________

Mailing Address: ___________________________ City/State/Zip:____

Date of Birth: _______________ Male [ ] Female [ ] SSN:____________________

Home phone: ____________________ Cell phone: _______________ Work Phone: ________________

Preferred phone number: ____________________ **Ethnicity**: [ ] Hispanic [ ] Non-Hispanic [ ] Prefer not to answer

Race: [ ] American Indian [ ] Asian [ ] Black [ ] Native Hawaiian [ ] Unknown [ ] White

Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ]

Referred by:______________________________ **Primary Care Doctor**:___________________________________

Email address:____________________________ **Preferred Language**:___________________________________

Employer: ________________________________ Were you injured? Yes [ ] No [ ] Date of injury:__________

Employer address: _________________________ On the job? Yes [ ] No [ ]

City/State/Zip: ____________________________ An auto accident? Yes [ ] No [ ]

Occupation:______________________________ Other:____

Do you have an attorney? Yes [ ] No [ ] Attorney's Name:_________________ Phone:_______________

Insurance Information

Primary Insurance

Carrier Name:____________________________

Subscriber's name: ________________________

Subscriber's date of birth: __________________

ID#:__________________ Group#:___________

Relationship to patient: _____________________

Responsible party: patient [ ] other [ ]

Secondary Insurance

Carrier Name:____

Subscriber's name: ____________________________________

Subscriber's date of birth: _______________________________

ID#:_______________________ Group#:__________________

Relationship to patient: __________________________________

Name of other responsible party:_________________________

Emergency Contact Information

Name:___________________________________

Phone:___________________________________

Relationship to patient:_____________________

Pharmacy:____

Location:____

Phone:____

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PATIENT REGISTRATION

Patient Name: Last:___________________________**First:**_________________________**Middle Initial**:_____________

Date of Birth: ______________________________

Bowling Orthopaedics wants to be helpful in every way possible. We are happy to assist you with prior authorization and filing claims. Some insurance policies require prior authorization for your office visit. Please check your policy and ensure authorization is received, if required. Your insurance policy remains a contract between you and your carrier, not Bowling Orthopaedics and your carrier.

Assignment/Authorization to release information:

Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, coinsurance and non-covered service amounts on the date of service. I authorize the release of my medical information to my insurance carrier, when necessary to process my claim(s). I authorize payment(s) of medical and surgical benefits to Bowling Orthopaedics. I agree to be responsible for any legal fees and/or fees incurred in the collection of charges for this account. I understand that I may be contacted via any method provided to Bowling Orthopaedics in the attempt to collect a debt. By signing this form, I agree to the above stated terms.

Financial Policy:

- Payment for services rendered is due at the time of service
- If you have health insurance, Bowling Orthopaedics will file your insurance for you and apply any payments and adjustments to your account. However, you will remain responsible to pay your copayments, deductibles and co-insurance amounts at the time services are rendered.
- If you do not have health insurance, a minimum deposit of $ 150.00 is required prior to your visit. At the conclusion of the visit the balance will be due and payable.

By signing this form, I understand and agree to the above policies.

Medicare Authorization:

I request that payment of authorized benefits be made on my behalf to Bowling Orthopaedics for any services furnished to me by their practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agent (or other insurance carrier) any information needed to determine those benefits or the benefits payable for related services.

Please keep in mind:

- Final responsibility for payment of services rendered remains with the patient.
- Patients who do not have insurance coverage are required to pay for their visit at the time of service.
- Patients who do have insurance must pay their copayment at the time of the office visit.

By signing this form, I understand and agree to the above policies, including the policy regarding Medicare reimbursement.

Signature of Patient/Guardian:____ Date:_______________________

Patient Name: Last:_______________________First:___________________Middle Initial:__ DOB:________

Acknowledgement of receipt of Notice of Privacy Practices

By signing below I am acknowledging that I have been provided with a copy of Bowling Orthopaedics' Notice of Privacy Practices pursuant to the Health Information Portability and Accountability Act of 1996 (HIPAA).

Signature of Patient/Guardian:__________________________________ Date:____________________

Evidence of the authority of the patient's representative must be attached to the last page of this acknowledgement. If the patient is unable to sign, please document the reason and initial.:_________________________________

[ ] I agree that Bowling Orthopaedics, PA and affiliated agencies may contact the numbers I have provided and if necessary leave a message. I also authorize to be contacted via email to the address I have provided. Methods of contact may include using pre-recorded / artificial voice messages and/or use of an automated dialing device as applicable. This is often times used for appointment reminders. By checking the box I agree to have read the above disclosure and agree that the creditor may contact me.

[ ] I hereby give Bowling Orthopaedics, PA permission to give information about my health and/or medical condition to the person(s) listed below:

Name	Relationship
____	____________________________________
____	____________________________________
____	____________________________________
____	____________________________________

Signature of Patient/Guardian:_______________________________________ Date:_______________

In order for you or anyone else to obtain information from our office about your health and/or medical condition by telephone, the party calling must share a unique and specific patient identifier with our staff. (**Password**)

Patient Identifier:____

Patient Name: Last:_____________________________First:______________________Middle Initial______

Prescription Policy Date of Birth:________________

The purpose of this policy is to prevent misunderstandings regarding prescription medications you may be prescribed. The medications may be prescribed for pain resulting from an injury or surgical procedure. This policy is to help you and our providers comply with the law regarding controlled pharmaceuticals.

Our office is unable to provide pain medication after business hours and on weekends. Exceptions are made on a case by case basis. **Prescription refill requests require at least 48 hours' notice**. Refills will only be called in to the pharmacy listed unless otherwise notified. Please make the necessary arrangements during our regular office hours. Evidence of altering prescriptions, multiple physicians prescribing, or the use of street drugs will result in dismissal as a patient of Bowling Orthopaedics.

- I will not lose my prescriptions as lost prescriptions will not be replaced
- I will take my medications as prescribed. If I use my medication at a greater rate than prescribed, it wil result in me being without medication for a period of time.
- I will not take other medications that may interact with narcotics without first consulting with our providers or their assistants.
- I will not sell, share or permit others to have access to my medications. I will not take someone else's medication.
- I will not drive or operate machinery while on pain medication because it can alter my mental status.
- I will not drink alcohol while taking these medications because combining these drugs with alcohol may cause severe drowsiness, low blood pressure or even death.
- I will report signs of dependence to narcotics, such as taking increased amounts or taking more often than ordered.
- I will submit to blood and/or urine drug screen testing if requested by Bowling Orthopaedics
- I agree to authorize the doctor and the pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, etc. of my medications. I agree to waive any applicable privilege or the right to privacy or confidentiality with respect to these authorizations.
- I will keep all my scheduled appointments. If I need to reschedule my appointment, I will do so a minimum of 24 hours in advance. If I miss an appointment, I will not be able to get a prescription refill and may be charged a $25.00 "no show" fee.
- If I give permission to someone else to pick up my prescription from the office, a photo ID is required and I am responsible if it is lost, stolen, destroyed or does not reach my possession.

I understand Bowling Orthoapedics may stop prescribing the medications if:

- I do not follow the above policies
- I do not show any improvement in pain or my activity level has not improved
- I develop rapid tolerance or loss of improvement from the treatment
- I develop significant side effects from the medication
- My behavior is inconsistent with the responsibilities outlined above, which may result in being prevented from receiving further care from Bowling Orthopaedics.

Patient's Signature: ______________________________________ Date:__________________

MEDICAL INTAKE FORM

Jack W. Bowling MD   Ryan Murphy, PA-C   Lacey Wildeboer, PA-C

①**Name**:____**Date of Visit**:_________________________

DOB: ______________ **Age**: _________ **Height**:____________ **Weight**:______________

Allergies:____

____

Allergies to: Latex: YES or NO   Adhesive: YES or NO

Reason for Visit:

____

Date of Onset/Accident/Injury/Surgery: ____

② **Pain level**:   0 1 2 3 4 5 6 7 8 9 10

(minimal)   (moderate)   (maximum)

Type of Pain: Constant [ ] Intermittent [ ] Frequent [ ] Occasional [ ] Wakes from sleep [ ]

Quality of Pain: Sharp [ ] Dull [ ] Stabbing [ ] Throbbing [ ] Aching [ ] Burning [ ] Radiating [ ]

Aggravated by: Sitting [ ] Standing [ ] Walking [ ] Climbing [ ] Kneeling [ ] Bending [ ] Stairs [ ] Weight bearing [ ]
Lifting [ ] Throwing [ ] Reaching [ ]

Other Symptoms: Swelling [ ] Tingling [ ] Numbness [ ] Weakness [ ] Stiffness [ ] Discoloration [ ]

Pain relieved by: Rest [ ] Elevation [ ] Ice [ ] Medication [ ] Other [ ]:____

Current Pain Medications:____

Current Physical Therapy/Exercises:____

Previous Treatments: (*please indicate date and type*)

Injection ___________________________ Physical Therapy ____________________ Brace/other_____________________________

Do You have Trouble Walking ONE City block/length of the mall?	Yes or No
Does your pain interfere with your daily life? (Bathing/Grooming/Dressing)	Yes or No
Are you able to perform daily tasks? (Mowing the lawn/Cooking/Cleaning)	Yes or No
Do you use any assistive devices to walk? (Cane/Walker/Wheelchair)	Yes or No
Do you feel unstable when walking?	Yes or No

• **ARE YOU CURRENTLY UNDER A CONTRACT WITH PAIN MANAGEMENT? YES or NO**

Pain Management Doctor? ____

For what medications? ____

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MEDICAL INTAKE FORM

③ Past Medical History: *please indicate any changes since your last visit*

Cardiac

□ High Blood Pressure
□ Heart Attack/MI
□ Irregular Heartbeat
□ Peripheral Vascular Disease
□ History of Blood Clots
□ Atrial Fib
□ Congestive Heart Failure
□ Do you have any Stents in your legs? Yes or No

Kidneys

□ Kidney Failure
□ Dialysis
□ Kidney Stones
□ Burning/ UTI

Neurological

□ Stroke
□ Nerve Damage
□ Depression
□ Confusion/Dementia
□ Other neurological problem____________________________
□ Anxiety
□ Bipolar Disease

Endocrine

□ Hypo/Hyperthyroid Problems
□ Diabetes
□ Type 1 or Type 2

Blood

□ HIV/AIDS
□ Hepatitis
□ History of blood transfusion
□ Other___________

Pulmonary

□ Asthma
□ COPD/Emphysema
□ TB
□ CPAP Therapy
□ Oxygen use ____Liters
□ Other_______

Arthritis

□ DJD/Osteoarthritis
□ Osteoporosis
□ Rheumatoid
□ Psoriatic

Other

□ Fibromyalgia
□ Lupus
□ Back/Spine History
□ Cancer _________________

Social History:

Do you smoke? □ yes □ no packs per day: ___________ Have you ever smoked? □ yes □ no

If so, when did you quit? _________________

Do you drink alcohol? □ yes □ no Drinks per day: ____________ Type of alcohol: Beer/Wine/Liquor

Drug Use? □Yes □No ________________

Living Situation:

□Alone □With Others

Single or Multi-Story Home

Pets: Yes /No #____

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Patient Name:____ **DOB**:_____________ **Date**:________________ **Chart#**_________

④ Review of Systems: ***please CIRCLE ALL of the ones that you are experiencing today:***

General: Chills, Fever, Night Sweats, Weight Gain, and Weight Loss
Skin: Lesions, Rash, and Skin Color Changes
HEENT: Headache and Vision Changes
Neck: Neck Pain
Respiratory: Difficulty Breathing
Cardiovascular: Chest Pain, Irregular Heartbeat (Type: ______________________) and Shortness of Breath
Gastrointestinal: Jaundice and Stomach Ulcers
Musculoskeletal: Decrease Range of Motion, Joint Pain, Joint Redness, Joint Stiffness, Joint Swelling
Hematology: Abnormal Bleeding, Anemia, and Blood Transfusion

⑤ Past Surgical History: *please list all surgeries you have had and/or any changes since your last visit.*

Procedure:	Surgeon:	Date:
________________________________	________________________________	___________
________________________________	________________________________	___________
________________________________	________________________________	___________
________________________________	________________________________	___________
________________________________	________________________________	___________
________________________________	________________________________	___________

Family History: Have you or anyone in your family experienced a complication with anesthesia? □ yes □ no

Please describe:____

____

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MEDICAL INTAKE FORM

Patient Name:____ **DOB**:_____________ **Date**:________________ **Chart#**_________

⑥ Medications: P*lease list* ***ALL*** *medications you are currently taking with the dosage including any supplements. If you are taking any narcotics, please list the provider that prescribe those to you.*

Medication **Dosage** **Frequency**

____
____
____
____
____
____
____
____
____
____
____
____
____
____

Pharmacy Name:__________________________Address:____

Pharmacy Phone: ________________________________ Fax: ____________________________

I certify that the above information is correct to the best of my knowledge. I will not hold Bowling Orthopaedics responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient/guardian:____ Date:________________