Steingart Orthopedics, P.C.

4045 E. Bell Road, Suite 105

Phoenix, AZ 85032

Ph. (602) 923-8500 Fax (602) 923-8502

Patient:________________________DOB___/___/___Account #____________________

New patient_____Est. pt. new injury____Referred by Dr.__________________________

******** **PLEASE READ THIS STATEMENT** ********

Per insurance company requirements, you may be required to fill out an accident/injury report prior to accepting your claim. To prevent a delay in acceptance of the claim or a possible denial please fill out this form and sign it below. With out a signature below your insurance company will not accept this form and you may subsequently be billed if your insurance denies payment.

If the problem you are being seen for was not from an accident please state time of onset and a brief statement explaining your problem.

Problem you are being seen for____

Date of onset or injury___/___/___Work injury___Auto accident___Sports injury___Other

Where did the injury/problem occur____

Describe how the problem began ____

____

____

____

____

____

Were you taken to emergency room Y/N. Which one_____________Taken by ambulance Y/N.
If no how long after injury_____. By what mode of transportation_______________________
You were seen in ER for what symptoms____

____

X-rays taken of_________________________________. Were you casted/splinted/braced.
Were other tests preformed Y/N. If Yes what_______________________.
If you did not go to ER, where did you first go____

PATIENT SIGNATURE _____________________________ DATE____/____/______

PAST MEDICAL HISTORY

check yes if you have had any of the following

	yes	no		yes	no
Diabetes			Hypertension (high blood pressure)		
Heart disease			Chest pain		
Shortness of breath			Asthma/breathing problems		
Stroke			Thyroid problems		
Ulcers/stomach pain			Constipation/diarrhea (for unknown reason)		
Migraine headaches			Depression/other mental disorder		
Fracture/dislocation			Other		

check yes if any member of your immediate family has had any of the following

	yes	no		yes	no
Diabetes			Hypertension		
Heart problems			Breathing problems		
Anemia			Arthritis		
Mental illness			Cancer		

List all surgeries and the year they were done.

____

____

____

What medications are you taking, and which doctor prescribed it for you.

____

____

____

List any allergies to drugs and your reaction to it.

____

____

____

Men only
When was your last prostate exam?__________ Was it normal?______ When was your last hernia exam?_______ Was it normal?_______

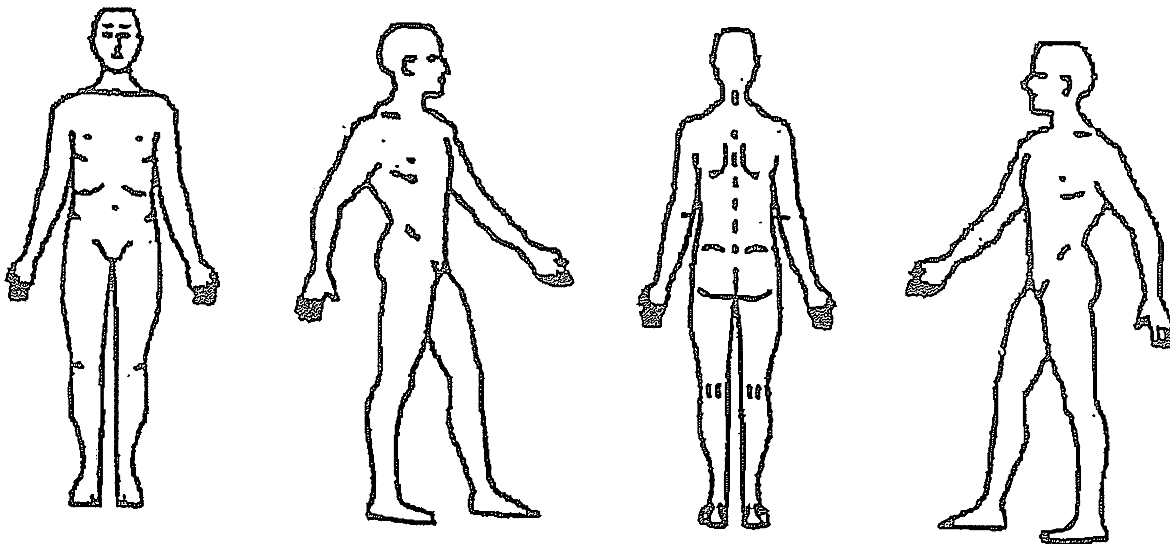
Women only
When was your last pap exam?________ Was it normal?_______ Are your menstrual periods regular?______ If not did they become irregular after the injury?______ Are you postmenapause?______ Have you had a tubal ligation?____year?_____
Hysterectomy?_____ year?____ Are you on estrogen replacement?______

Do you smoke? yes no If yes how many packs per day?_____ Do you use other tobacco products? yes no Do you drink alcohol? yes no How much per day? _____

Describe any symptoms on the appropriate line. Example: headaches after the accident sharp constant; now dull and throbbing, comes and goes.

SYMPTOMS EXPERIENCED	AFTER THE ACCIDENT	NOW
HEADACHES		
VISION PROBLEMS		
DIZZINESS		
MEMORY PROBLEMS		
LOSS OF COORDINATION		
SLEEP DISORDERS		
ANXIETY		
DEPRESSION		
MOOD SWINGS		
NUMBNESS (where)		
PAIN (where)		
OTHER		
OTHER		
OTHER		

Indicate with an X the areas of your body injured



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Patient's Name: ____________________ DOB: ____________________

Social Security Number: Date:

Notice of Privacy Practices for Steingart Orthopedics, P.C.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Steingart Orthopedics, P.C. is committed to protecting the confidentiality of information about you and is required by law to do so. This notice describes how we may use information within Steingart Orthopedics, P.C. and describes the rights you have concerning your own health information.

Steingart Orthopedics, P. C. may use information about you to provide you with medical services and supplies. We may also disclose information about you to others that need that information to treat you, such as, doctors, technicians, medical students and medical equipment providers and others involved in your care. We may also use and disclose information about you to contact you to remind you of an upcoming appointment, to inform you about billing issues, possible treatment options, or to tell you about health-related services available to you.

Steingart Orthopedics, P. C. may use and disclose information about you to get paid for medical services and supplies we provide for you. For example, your health plan may request to see parts of your medical record before they will pay us for your treatment.

Steingart Orthopedics, P.C. may use or disclose information about your for research projects, such as studying the effectiveness of a treatment you received.

You have the rights to look at information about you and to get a copy of that information. This includes your medical record, billing record and other records used to make decisions on your health care. To request information about you, you must submit a written request for medical information for your records. If you request a copy of your information, we will have your records copied by an outside company. The law requires us to keep the original records.

Federal, states and local laws do not require patient consent to disclose information in which we are required to report. We are required to report child abuse and neglect, elderly abuse, etc. We are also required to give information to the state workers compensation program for work-related injuries.

My signature indicates I have read and reviewed The Notice of Privacy Practices for Protected Health Information. I agree and consent to allow Steingart Orthopedics, P.C. to use and disclose my health information to carry out treatment, payment and healthcare operations.

____________________ ____________________ ____________________

Patient or Legal Guardian Relationship to Patient Date

Steingart Orthopedics, P.C.

4045 E. Bell Rd, Suite 105

Phoenix, Arizona 85032

602-923-8500 (phone) 602-923-8502 (fax)

Patient_______________________________________

Employer_____________________________________

Claim Group__________________________________

SS#/ID#_______________________________________

I hereby instruct and direct to (patient insurance co.)______________________ to pay by check made out and mailed to: Steingart Orthopedics; 16601 North 40th St., Suite 204; Phoenix, AZ 85032-3356

If my current policy prohibits direct payment to Steingart Orthopedics, I hereby instruct and direct you to make out the check and mail it as follows:

Patient name ____

4045 E. Bell Road, Suite 105; Phoenix, Arizona 85032

for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of the Assignment is considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Steingart Orthopedics to initiate an appeal and/or complaint to my insurance company and/or Insurance Commissioner for any reason on my behalf.

Dated, this day of ,20

_________________________________ _________________________________

Signature of Policy Holder Witness

Steingart Orthopedics, P.C.
4045 East Bell Road, Suite 105
Phoenix, AZ 85032

Is your office visit related to an accident? If yes, please fill out this form. If not please hand back to the receptionist.

1. Patient Name:____________________
   Address:____________________
   City:__________State:__________Zip Code:__________
   Home phone:__________Work:__________Cell:__________
2. How did accident happen?
   Auto:________Home:________Slip/Fall:________Work:________
   Date of accident:__________Location:__________
3. If you were injured in an auto accident, who was at fault:
   Self:________Other Driver:__________
   Information on the driver:
   Name:____________________
   Address:____________________
4. Have you heard from the other driver's insurance company? Yes______No______
   If yes, please provide the following:
   Name of insured:____________________
   Name of insurance company:____________________
   Address of insurance company:____________________
   Claim Number:__________Adjustor:__________
   Phone number:____________________
5. Was the accident investigated by the police? Yes________No________
   If yes, what city investigated and were citations issued: __________
   ____
6. Did you have insurance on your vehicle?____________________
   Did you have med pay coverage?____________________
   If yes, please provide the claim number and billing information for the med pay:
   ____
   ____
   ____
7. Was any other person or business at fault in your opinion? Yes________No________
8. If you have legal counsel, please provide the name, address and phone number.
   ____
   ____
   ____
9. If you do not have legal counsel, would you like us to provide you with the name of one that we work with? Yes________ No________

Additional information:____________________
Patient signature:____________________
Date signed:____________________