

POSM NEW PATIENT PACKET

Patient Last Name: _____ First Name: _____ MI: _____
Address: _____
City: _____ State: _____ ZIP: _____
Home Phone: _____ Work Phone _____ Cell _____
Social Security # _____ Email * _____
Marital Status _____ Height _____ Weight _____ Dominant Hand _____
Date of Birth: ____/____/____ Age: _____ Gender: Male _____ Female _____
Hobbies/Sports _____

Employer Information

Occupation _____
Company Name _____
Company Address _____

Emergency Contact

Last Name, First Name _____
Phone _____
Relationship to Patient _____

Primary Care Physician

Last Name, First Name _____
Phone Number _____

Referral Information

MD _____ Patient _____ Attorney _____
Hospital _____ Staff Member _____ Publication _____
Insurance _____ Search _____
Website _____ Engine _____ Ad _____

Insurance Information

Primary Insurance Carrier _____
Policy Holder Self Spouse Parent Partner
Policy Holder, if other than self - (Last Name, First): _____
Date of Birth: ____/____/____ SSN: _____

Insurance Information

Secondary Insurance Carrier _____
Policy Holder Self Spouse Parent Partner
Policy Holder, if other than self - Last Name, First: _____
Date of Birth: ____/____/____ SSN: _____

Workers Compensation Information

* Only fill out if injury was job related

Insurance Carrier _____

Billing Address _____

City _____ State _____ ZIP _____

Workers Compensation Board Number _____

Carrier Case #/Claim # _____

Case Manager (Last Name, First): _____

Billing Address _____

City _____ State _____ ZIP _____

Phone _____

Date of Injury _____ Body Part _____

Where did the original injury occur (City, State)? _____

Are you now or have you in the past, been involved in active litigation or had a settlement and/or closure involving this injury? YES or NO

Attorney (Last Name, First): _____ Phone: _____

Injury History

Location of Symptom	Left	Right	How did injury occur?	
Hand	<input type="checkbox"/>	<input type="checkbox"/>	Sport injury	<input type="checkbox"/>
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Job-related	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Auto Accident	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>
Ankle	<input type="checkbox"/>	<input type="checkbox"/>		
Other:	<input type="checkbox"/>	<input type="checkbox"/>		

If job-related

- was injury reported to employer Yes No

- are you currently working for this employer Yes No

Duration of Symptoms:

Symptoms made worse by:

Symptoms made better by:

Treatment

Has another physician treated/seen you for this injury? Yes No

If yes, (Last Name, First, Phone) _____

Personal Medical History

Women only: are you or do you have reason to believe you may be pregnant? Yes No

Prior Surgeries
(please list year, surgery, doctor)

Medications
(include over the counter)

Women only: are you taking oral contraceptive medication? Yes No

Medical Allergies

Allergies To: Tape Iodine Latex None

Smoking History Never Currently Smoke Quit Smoking
 # packs per day _____ If quit, when last smoked: _____

Alcohol Use Never Rare Social Frequent

Major Family Medical Conditions

Review of Systems
 Make check mark or circle for all that apply.

	Do you have the problem?	Do you receive treatment for it?	Does it limit your activities?
Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Lung Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Ulcer or Stomach Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Liver Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia or other blood disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Depression	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Osteoarthritis, degenerative arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Back pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Rheumatoid arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Thyroid disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

* We may use your email to send you periodic updates on the Orthopaedic Foundation for Active Lifestyles and/or Plancher Orthopaedics & Sports Medicine.

Written Acknowledgement of Receipt of Notice of Privacy Practices

Last Name

First Name

Date of Birth

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that if I have any further questions or complaints I may contact:

Plancher Orthopaedics & Sports Medicine
203-863-2003

I also understand that I am entitled to receive updates upon my request if the Plancher Orthopaedics & Sports Medicine Notice of Privacy Practices is amended or changed in a material way.

Signature

Relationship to Patient

Date

TO BE COMPLETED BY COVERED ENTITY IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

On, _____, I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-name patient, but was unable to because:

Patient declined to sign this Written Acknowledgement

Patient did not understand the request to sign the Written Acknowledgement

Other (specify) _____

Name and Title of Employee

Date

Assignments of Benefits

Your signature is required for us to protect any insurance claims and to ensure payment of services rendered.

I authorize release of all medical information necessary to process my insurance claims or that is pertinent to my medical and/or surgical benefits, including major medical benefits to which I am entitled to the above named physician or clinic. This assignment will remain in effect until revoked by me in writing.

A photocopy of the assignment is to be considered as valid as the original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Signature

Date

Signature of Parent, if patient is a minor

Date

Billing Waiver for Insurance Patients:

I understand that my insurance carrier may deny payment for certain screenings, labs, tests, DMEs, supplies, or injections in the doctor's office. It is my right to refuse these, and my responsibility to pay for them if I accept to receive them.

I also understand that any DME and/or supplies that are purchased are non-refundable.

Insurance Release & Authorization:

I, _____, clearly understand the above information, and accept responsibility for my bill.

Patient Signature _____

Date _____

Plancher Orthopaedic and Sports Medicine, PLLC

Kevin D. Plancher, M.D.

TO OUR PATIENTS:

Please review the following Office Policies:

Your current **insurance card** is required at each visit.

Co-payments are required by your insurance plan and must be paid at each visit. If not paid at time of visit, a \$10 fee will be added. If a referral is needed with your health plan, it is your responsibility to make sure it has been received.

Payment in full for all services not covered by your insurance plan must be paid each visit.

FEES FOR MISSED VISITS OR LATE CANCELLATIONS WILL BE CHARGED AS FOLLOWS:

OFFICE VISITS

Without 24 hour notice: \$25.00 charge

SURGERIES

There will be a \$250 cancellation fee for any surgeries that are cancelled without a medical reason.

If you request any medical records, forms or x-ray/CD's there is a fee that must be paid before we can release any information.

We are open Monday through Friday 8:30am- 5:30pm. Doctors are available 24/7 for **EMERGENCIES AFTER 5:30PM**, weekends and holidays.

Thank you for your understanding and cooperation. We look forward to serving you,

Plancher Orthopaedics Physicians and staff.

I have reviewed the above policy:

Patient's Signature

Date

**POSM / OFALS
HEALTH SURVEY SF-12**

Medial Record #

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Exam Date:

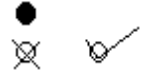
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INSTRUCTIONS: This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Please answer every question by marking the appropriate box. If you sure about how to answer a question, please give the best answer you can.

Shade circles like this: ●

Not like this: ○



1) In general, would you say your health is:						
○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor						
The following items are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?						
		Yes, limited	Yes, limited a little	No, not limited at all		
2) Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf		○	○	○		
3) Climbing several flights of stairs		○	○	○		
During the <u>past 4 weeks</u> , have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u> ?						
		Yes	No			
4) Accomplished less than you would like		○	○			
5) Were limited in the kind of work or other activities		○	○			
During the past week, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?						
		Yes	No			
6) Accomplished less than you would like		○	○			
7) Didn't do work or other activities as carefully as usual		○	○			
8) During the <u>past 4 weeks</u> , how much did <u>pain</u> interfere with your normal work (including both work outside the home and housework)?						
		○ Not at all	○ Quite a bit			
		○ A little bit	○ Extremely			
		○ Moderately				
These questions are about how you feel and how things have been with you <u>during the past 4 weeks</u> . For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the <u>past Weeks</u> -						
	All of the Time	Most of the Time	A good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
9) Have you felt calm and peaceful?	○	○	○	○	○	○
10) Did you have a lot of energy?	○	○	○	○	○	○
11) Have you felt downhearted and blue?	○	○	○	○	○	○
12) During the <u>past 4 weeks</u> , how much of the time has <u>your physical health or emotional problems</u> interfered with your social activities (like visiting with friends, relatives, etc.)?						
○ All of the time		○ Some of the time		○ None of the time		
○ Most of the time		○ A little of the time				

