PREFERRED PEDIATRIC ORTHOPEDIC SURGERY

PATIENT INFORMATION Date: _____

Patient Full Name: _____ Sex: _____ Date of Birth: _____

Age: _____ Email: _____

☐ Home # _____ ☐ Cell # _____ Check preferred contact #

Address: _____ City: _____ State: _____ Zip: _____

Child Social Security Number: _____ Ethnicity: _____

Parents Names: _____ Referred by: _____

Family members treated by Dr. Joffe: _____

PEDIATRICIAN INFORMATION

Pediatrician's Full Name: _____ Pediatrician's Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Reason for today's visit: _____

Please select: Right: ☐ Left: ☐ Both: ☐ Spine: ☐ Other: ☐ Please explain: _____

Date problem began: _____ How did this occur? _____

Please select one of the following if applicable: ☐ School Accident ☐ Chronic Condition

☐ Motor Vehicle ☐ Sport Injury ☐ Noticed at Birth

Was the patient seen in the Emergency Room? _____ Date of Visit: _____

Which Emergency Room? _____

PATIENT INFORMATION Height: _____ Weight: _____ Last Menstrual Period (date): _____

Please list any allergies: _____

Are you pregnant or is there any chance of pregnancy? Yes: ☐ No: ☐

Medical History (Please check all that apply):

☐ Asthma ☐ Fractures

☐ Seasonal Allergies ☐ Sprains

☐ Cerebral Palsy ☐ Dislocation

☐ ADHD ☐ Bone or Joint Infections

☐ Emotional or Psychiatric Disorder ☐ Scoliosis

☐ Other (Please List): _____

Please list all current medications (tablets, patches, inhalers, drops, liquids, ointments, injections, etc.) including prescription, over-the-counter, herbal, vitamin, and dietary supplements:

Medication	Dose / How often	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does the patient smoke? Yes: ☐ No: ☐ Do any family members smoke? Yes: ☐ No: ☐

Please document any unlisted Medical Problem: _____

Please document any surgeries: _____

Birth History: _____ Birth Weight: _____

Please select delivery presentation type: Head First: ☐ Breech: ☐ Twin/Multiples: ☐ C-Section: ☐

In ICU after delivery? _____ Please list any perinatal complications _____

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YOUR INSURANCE COMPANY

In the past few years the number of different health insurance programs has increased at an amazing rate. Even within one company, there may be several programs with varying benefits and requirements. There is no way we can possibly know or keep up to date with each program's provisions.

- Some programs require a specific facility to be used for your MRI, CT Scans, ultrasounds, or blood tests
- Some programs require pre-authorization, while others do not
- Some insurance companies require PATIENTS notify them of hospital admissions or trips to the Emergency Room

OUT OF NETWORK COVERAGE

You should be aware that in the event an out of network insurance plan covers all or part of your treatment, payment for some may be mailed directly to you. As a courtesy to our patients we file insurance; however, we will not become involved in disputes between you and your insurance companies regarding deductibles, co-payments, covered charges, secondary insurance, or other matters regarding payment.

APPEALS

I hereby authorize Preferred Pediatric Orthopedic Surgery to appeal any denial or fair compensation for coverage by my health care provider for services rendered by Preferred Pediatric Orthopedic Surgery to my child. I further understand and acknowledge that any payment issued by my insurance carrier for services rendered by Preferred Pediatric Orthopedic Surgery as a result of this appeal must be remitted to Preferred Pediatric Orthopedic Surgery. In the instance my appeal is denied, I remain responsible for all payments due and owing Preferred Pediatric Orthopedic Surgery for services rendered.

RECORDS

You, the patient, are entitled to any and all records that pertain to your medical condition. For medical/legal reason we never release the original records. Records are only released to the patient or someone that the patient specifically designates. Copies of the office assessments, outside test results, and x-rays are available. If you would like to view your records or obtain copies of your records the office will comply with your request within 30 days after a written release is received. Please note that there is a fee for copying records and x-rays.

PATIENT PRIVACY

In order to protect your privacy and in accordance with Federal Law, we do not leave confidential medical information on answering machines or with anyone other than the patient or patient's legal guardian without prior authorization. Please read and sign below acknowledging receipt of the policy.

Please indicate below your preference:

☐ We may leave detailed messages on this answering machine # _____

☐ Do not leave detailed messages on any answering machine

☐ Permission to fax medical instructions to my child's school

Signature: _____ Date: _____

Please print your name: _____

*__If over the age of 18__ please list who we can speak to other than yourself regarding medical information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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Insurance Information

Primary Insurance Information

Primary Insurance Company Name: _____ Phone Number: _____

Subscriber ID Number: _____ Group Number: _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

Person Responsible for Account (Guarantor): _____ Phone Number: _____

Relationship to Patient: _____ Guarantor's Birth Date: _____ Guarantor's SS #: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone #: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance Information

Secondary Insurance Company Name: _____ Phone Number: _____

Subscriber ID Number: _____ Group Number: _____

Insurance Co. Address: _____ City: _____ State: _____ Zip: _____

Person Responsible for Account (Guarantor): _____ Phone Number: _____

Relationship to Patient: _____ Guarantor's Birth Date: _____ Guarantor's SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone #: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Assignment and Release

I hereby authorize payment directly to Dr. Joffe, all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize the above noted doctor and/or provider or supplier of services in this office to release any information required to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ Date: _____