



**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 or Dr. Pehlivan \_\_\_\_\_

**PEDIATRICIAN INFORMATION**

Pediatrician's Full Name: \_\_\_\_\_ Pediatrician's Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Please Circle: Right Left Both Spine Other: \_\_\_\_\_

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 / Urgent Care? \_\_\_\_\_

Date of Visit: \_\_\_\_\_ Which Emergency Room / Urgent Care? \_\_\_\_\_

**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):

- |  |   |
|--|---|
| <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Fractures                |
| <input type="checkbox"/> Seasonal Allergies                | <input type="checkbox"/> Sprains                  |
| <input type="checkbox"/> Cerebral Palsy                    | <input type="checkbox"/> Dislocation              |
| <input type="checkbox"/> ADHD                              | <input type="checkbox"/> Bone or Joint Infections |
| <input type="checkbox"/> Emotional or Psychiatric Disorder | <input type="checkbox"/> Scoliosis                |
| <input type="checkbox"/> 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 \_\_\_\_\_



**YOUR INSURANCE COMPANY**

In the past few years, the number of different health insurance plans has increased. Even within one company, there may be several plans with varying benefits and requirements.

**It is your responsibility to ensure that proper authorization and referrals for the services provided from PPOS are covered.**

- Some plans require REFERRALS from your Primary HealthCare Physician (The referral must be received before the appointment)
- Some plans require a specific facility to be used for your MRI, CT Scans, Ultrasounds, Blood Work and Surgical procedures

**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: \_\_\_\_\_



**Insurance Information**

\*If you have your insurance card with you today, fill out the **bold** sections only

**Primary Insurance Information**

**Primary Insurance Company Name:** \_\_\_\_\_

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: \_\_\_\_\_

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: \_\_\_\_\_