Advanced Orthopaedics and Sports Medicine, P.C.

Bryan Matanky, MD

Roland Benigno, PA-C Kristi Grover, PA-C

1760 E Florence Blvd. Suite 120 Casa Grande, Az 85122

Phone: (520) 426-1000 Fax: (520) 426-1395

PATIENT INFORMATION

Patient Name(**Last, First, MI**):_____SSN:_____

DOB: _____ □ M □ F Parent/Guardian Name: _____

Address: _____ City, State, Zip: _____

Mailing Address:_____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Language: _____ Race: _____ Email Address: _____

School: _____ Grade: _____

City, State, Zip: _____School Phone: _____

May we discuss the patients injury with the school? □ Y □ N

Emergency Contact(***not living with you***):_____ Phone: _____

Relationship to patient: _____ May we discuss the injury with this person? □Y □ N

RESPONSIBLE PARTY

Responsible Party Name:_____ Relationship to Patient: _____

Address (if different than above):_____

City, State, Zip: _____ Phone (if different then above): _____

INSURANCE INFORMATION

SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____

PRIMARY INSURANCE_____

SECONDARY INSURANCE_____

_____ _____

Signature **Today's Date**

_____

Print Name

_____

Relationship to Patient

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MEDICAL HISTORY

Today's Date: _____

Patient Name:_____ □ male □ female

Date of Birth: _____ Age: _____

Home Phone: _____

Height: _____ Weight: _____(pounds)

Reason for visit today: _____

If Accident type and date: _____

Primary Care Physician (required by Medicare and AHCCCS):_____

City, State, Zip: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Nearest cross-streets: _____ City & St: _____

Patient is: □ right handed □ left handed

DRUG ALLERGIES	**FAMILY HISTORY**
NAME: REACTION:	Check all that apply Family Member
	□ Heart Disease
	□ High Blood Pressure
	□ Stroke
□ NONE	□ Cancer
ARE YOU ALLERGIC TO LATEX? □ ***Y*** □ ***N***	□ Glaucoma

CURRENT MEDICATIONS & DOSAGE	□ Diabetes
	□ Epilepsy/convulsion
	□ Bleeding disorder
	□ Kidney disease
	□ Thyroid disease
	□ Osteoporosis
	□ Malignant Hyperthermia
	□ Thrombophlebitis/DVT(blood clots) in legs
□ NONE	□ Pulmonary embolus

SURGERY HISTORY

REASON	DATE
□ NONE	

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Patient Name:_____

MEDICAL HISTORY

(Please check all that apply)

□ HEADACHES	□ ANXIETY	□ LIVER DISEASE
□ VENEREAL DISEASE	□ HIGH BLOOD PRESSURE	□ MI – HEART ATTACK
□ ANEMIA	□ ULCER DISEASE	□ STROKE/TIAs
□ CONGENITAL HEART DISEASE	□ INTESTINAL DISEASE	□ INCONTINENCE

□ GOUT	□ EPILEPSY	□ CIRCULATORY DISORDER
□ LACTOSE INTOLERANT	□ ARTHRITIS	□ FATIGUE
□ HYPERLIPIDEMIA	□ KIDNEY DISEASE	□ OSTEOPOROSIS
□ SHORTNESS OF BREATH	□ CONGESTIVE HEART FAILURE	□ URINARY DISORDER
□ DIABETES	□ HEART PALPITATIONS	□ ARRHYTHMIA
□ SEXUAL DISORDER	□ ENDOCRINE DISEASE	□ HEART MURMER
□ ALLERGIES/HAY FEVER	□ MENSTRAL DYSFUNCTION	□ BLEEDING DISORDER
□ CHEST PAIN	□ ASTHMA	□ BOWEL IRREGULARITY
□ BLOOD TRANSFUSION	□ DIZZINESS/FAINTING	□ COPD
□ PROSTATE DISEASE	□ RHEUMATIC FEVER	□ SCARLET FEVER
□ AIDS	OTHER:	OTHER:

HABITS

SMOKING:	□ CURRENTLY	□ PREVIOUSLY	□ NEVER	
ALCOHOL:	□ SOCIAL	□ PREVIOUSLY	□ NEVER	□ OTHER_____
ASPIRIN:	□ CURRENTLY	□ PREVIOUSLY	□ NEVER	
COFFEE:	□ CURRENTLY	□ PREVIOUSLY	□ NEVER	
DRUG USE (ILLICIT):	□ CURRENTLY	□ PREVIOUSLY	□ NEVER	□ MEDICAL
STEROIDS:	□ CURRENTLY	□ PREVIOUSLY	□ NEVER	□ MEDICAL

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NOTICE OF PRIVACY PRACTICES

To our patients:

This notice describes how health information about you(as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclose of your health information under special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. Or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official
8. For Workers Compensation and similar programs

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care such as family members and friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Medical Records.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be in writing and submitted to Jennifer, Office Manager.
5. Right to copy of this notice. You are entitled to receive a copy of this NOTICE OF PRIVACY PRACTICES. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint wit our practice, please contact Jennifer, Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Jennifer, Office Manager.

I hereby acknowledge that I have been presented with a copy of the Advanced Orthopaedics and Sports Medicine, P.C. **Notice of Privacy Practices.**

Signature: _____
Print Name: _____
Print Patient Name: _____
Today's Date: _____

I authorize AOSM to discuss above named patient's health/medical and or billing information with the following person(s): ***(If left blank, we are unable to discuss your information with anyone.)***

Name:	Relationship to patient:
1. _____	_____
2. _____	_____
3. _____	_____

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AUTHORIZATION FOR:

ASSIGNMENT OF BENEFITS RESPONSIBILITY FOR NON-COVERED SERVICES RELEASE OF INFORMATION

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS PAYABLE BY ANY FEDERAL OR STATE HEALTH CARE PROGRAM OR COMMERCIAL PAYER BE MADE EITHER TO ME ON MY BEHALF TO ADVANCED ORTHOPAEDICS & SPORTS MEDICINE, P C FOR ANY SERVICES FURNISHED TO ME BY ITS PHYSICIANS OR EMPLOYEE AT ANY LOCATION. I AUTHORIZE ADVANCED ORTHOPAEDICS & SPORTS MEDICINE P C TO REALEASE TO ITS BILLING AGENTS. THE HEALTH CARE FINANCING ADMINISTRATION. ITS AGENTS AND MY INSURER AS APPLICABLE, ANY INFORMATION (INCLUDING, BUT NOT LIMITED TO INFORMATION REGARDING DRUG AND ALCOHOL PROGRAM PARTICIPATION, DIAGNOSIS, PROGNOSIS, TREATMENT OR REFERRAL) NEEDED TO DETERMINE THESE BENEFITS, THE BENEFITS PAYABLE FOR RELATED SERVICES OR TO OBTAIN PAYMENT FOR SERVICES PROVIDED. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT TO THE RELEASE AT ANYTIME, EXCEPT TO THE EXTENT RELIED UPON BY ADVANCED ORTHOPAEDICS & SPORTS MEDICINE, P C OR THE DISCLOSURE IS AUTHORIZED BY LAW. THIS CONSENT TO THE RELEASE OR PAYMENT INFORMATION REMAINS VALID UNTIL EXPRESSINGLY REVOKED BY ME IN WRITING I UNDERSTAND THAT I AM PRIMARILY FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF ANY SERVICES PROVIDED.

□ I authorize Advanced Orthopaedics & Sports Medicine to send automated reminders regarding my appointment to the designated number I have provided.

_____ _____

Signature Today's Date

_____

Print Name

_____

Print Patient Name