What is your email address, may we use email to contact you? _____

What brings you in to the office today? _____

Have you had any tests done since your last visit? What? Where? _____

Are you feeling better or worse since your last visit? _____

Have you had surgery recently? What surgery? Date? _____

☐ **GENDER:** MALE FEMALE

☐ **LANGUAGES:** _____

☐ **RACE:** AMERICAN INDIAN ASIAN BLACK NATIVE HAWAIIAN WHITE OTHER

☐ **ETHNICITY:** HISPANIC NON-HISPANIC OTHER

☐ **PROBLEM LIST:** DIAGNOSIS:_____

☐ **PATIENT EDUCATION GIVEN:**

☐ **VITALS:** HEIGHT _____ B/P _____/_____
WEIGHT _____

☐ **SMOKING STATUS:** CURRENT SMOKER DAILY SOME DAYS UNKNOWN HOW OFTEN
NON- SMOKER
FORMER SMOKER
SMOKING STATUS UNKNOWN

☐ **PROCEDURE CODE:**

☐ **PHARMACY:** _____
(NAME ADDRESS PHONE)

☐ **CONSENT BOX:**

☐ **ALLERGIES:** MEDICATION ALLERGIES: _____ NKDA

OTHER ALLERGIES: _____

☐ **ACTIVE MEDICATION LIST:** _____
(MAKE SURE ENTERED IN COMPUTER IN RX MODULE)

☐ **CLINIC SUMMARY:** GIVEN TO PATIENT

INJECTION: Depomedrol Orthovisc

☐ **RETURN APPOINTMENT:** _____

INVESTIGATIONS: MRI EMG

7656 Poplar Pike
Germantown, TN 38138
P 901.333.2525
F 901.786.6635

TRI-STATE ORTHOPAEDICS, LLC.
APURVA R. DALAL, M.D.

1264 Wesley Dr. Ste 502
Memphis, TN 38116
P 901.346.5488
F 901.346.4774

PATIENT REGISTRATION

PATIENT NAME: _____ DATE: _____

SSN: _____ DOB: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE: _____ CELL: _____

EMPLOYER: _____ ADDRESS: _____

CITY/STATE/ZIP: _____ WORK PHONE: _____

IS THIS A WORK RELATED INJURY? ○ YES / ○ NO IF YES, DATE OF INJURY? _____

IS THIS AN ACCIDENT RELATED INJURY? ○ YES / ○ NO IF YES, DATE OF ACCIDENT? _____

WHO REFERRED YOU? _____

PCP NAME: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

NAME OF INSURANCE: _____

NAME OF POLICY HOLDER: _____

SSN OF POLICY HOLDER: _____ DOB: _____

RELATION TO PATIENT: _____ IS THERE OTHER INSURANCE? ○ YES / ○ NO

ASSIGNMENT OF BENEFITS

I hereby authorize, (a) payment of insurance benefits to be made directly to TRI-STATE ORTHOPAEDICS, LLC., (b) release of information to insurance companies as needed to file payment, (c) TRI-STATE ORTHOPAEDICS, LLC., to obtain records from other sources as may be necessary in the diagnosis treatment, and (d) understand that I am financially responsible, for payment to TRI-STATE ORTHOPAEDICS, LLC., for charges related to services provided to me or my dependents. I also understand that my failure to make payments may result in TRI-STATE ORTHOPAEDICS, LLC proceeding with collection agency actions which may add up to 40 percent added to the balance.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM
I have received a copy of TRI-STATE ORTHOPAEDICS, LLC., Notice of Privacy Practices.

_____ DATE: _____

SIGNATURE OF RESPONSIBLE PARTY

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PATIENT NAME: _____ DATE: _____

WHO REFERRED YOU: _____

REASON FOR SEEKING MEDICAL ATTENTION: _____

RIGHT ☐ LEFT ☐ BOTH ☐

☐ SHOULDER ☐ ELBOW ☐ PELVIS ☐ ANKLE
☐ HIP ☐ KNEE ☐ WRIST ☐ FOOT
☐ NECK ☐ LOWER BACK ☐ HAND

WHAT HAPPENED TO YOU? WHERE AND HOW? _____

WHAT DIFFICULTIES ARE YOU HAVING DUE TO CURRENT CONDITION? _____

DATE OF INJURY/ONSET OF PAIN: _____

RATE YOUR PAIN: ☐ MILD ☐ MODERATE ☐ SEVERE ☐ EXTREMELY SEVERE

IS THIS RELATED TO AN AUTOMOBILE ACCIDENT OR WORK RELATED? ○ YES / ○ NO
IF YES, PLEASE EXPLAIN: _____

HAVE YOU FILED A WORKMAN'S COMPENSATION CLAIM? ○ YES / ○ NO

DO YOU HAVE ANY MENTAL ILLNESS: ☐ BIPOLAR DISORDER ☐ SCHIZOPHRENIA

☐ ANXIETY ☐ ANGER ☐ DEPRESSION ☐ OTHER: _____

ARE YOU PLANNING TO APPLY FOR DISABILITY? ○ YES / ○ NO

IF YOU ARE CURRENTLY NOT WORKING, WHEN DID YOU STOP WORKING? _____

WHAT DOES YOUR JOB REQUIRE YOU TO DO? _____

PATIENT INITIALS

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PATIENT NAME: _____ CHART NUMBER: _____

ARE YOU RIGHT OR LEFT HANDED? ☐ RIGHT HANDED ☐ LEFT HANDED

HEIGHT: _____ WEIGHT: _____

HAVE YOU EVER BEEN TREATED FOR YOUR PRESENT CONDITION? ○ YES / NO ○

IF SO, PLEASE LIST NAME OF DOCTOR: _____

DO YOU HAVE ANY XRAYS, MRIS, OR OTHER TESTS DONE ON THIS CONDITION? ○ YES / ○ NO

DID YOU BRING THEM WITH YOU? ○ YES / ○ NO LOCATION OF TEST: _____

DO YOU HAVE A LAWYER FOR THIS CONDITION? ○ YES / ○ NO

WHAT IS YOUR OCCUPATION: _____

HAS YOUR HEALTH BEEN GOOD IN GENERAL? EXPLAIN: _____

MEDICATIONS AND ALLERGIES

PLEASE LIST ALL ALLERGIES: FOOD, MEDICINE, LATEX, SERUMS, ETC.

_____

PLEASE LIST ALL MEDICATIONS, VITAMINS OR SUPPLEMENTS AND DOSAGES YOU ARE TAKING

_____
_____
_____
_____
_____
_____
_____
_____

MEDICAL HISTORY - PLEASE CHECK ALL THAT APPLY

☐ ARTHRITIS	☐ SWOLLEN GLANDS NECK / ARMPIT	☐ EPILEPSY / BLACKOUTS
☐ BIRTH CONTROL PILLS	☐ EXPOSURE TO HIV	☐ SHORTNESS OF BREATH
☐ BLOOD TRANSFUSIONS	☐ HIV POSITIVE	☐ HIGH BLOOD PRESSURE
☐ CHRONIC COUGH	☐ GOITER	☐ PAIN / PRESSURE IN CHEST
☐ COAGULATION DISORDERS	☐ ASTHMA	☐ WEAKNESS / PARALYSIS
☐ DIABETES	☐ IRREGULAR VAGINAL BLEEDING	☐ LATEX ALLERGY
☐ DIZZINESS / FAINTING SPELLS	☐ NERVOUSNESS / DEPRESSION	
☐ EASY BRUISING OR BLEEDING	☐ NOSE BLEEDS / SINUS TROUBLE	

- DO YOU SUFFER FROM SLEEP APNEA? ○ YES / ○ NO USE A CPAP MACHINE? ○ YES / ○ NO
- ARE YOU CURRENTLY IN A DRUG REHAB PROGRAM? ○ YES / ○ NO IN THE PAST? ○ YES / ○ NO
- HAVE YOU BEEN, OR ARE YOU CURRENTLY USING A PAIN MANAGEMENT CLINIC? ○ YES / ○ NO
- LIST ANY BROKEN BONES OR ACCIDENTS: _____

_____
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PATIENT NAME: _____ CHART NUMBER: _____

REVIEW OF SYSTEMS - PLEASE CHECK ALL THAT APPLY

- ☐ STROKE OR BRAIN DISORDERS
- ☐ LUNG DISEASE
- ☐ HEART DISEASE
- ☐ VASCULAR DISEASE
- ☐ RHEUMATIC FEVER
- ☐ STOMACH OR INTESTINAL DISORDERS
- ☐ KIDNEY OR URINARY DISORDERS
- ☐ UNUSUAL COMPLICATIONS FROM CHILDHOOD DISEASE
- ☐ BIRTH ABNORMALITIES
- ☐ RENAL FAILURE
- ☐ PACEMAKER
- ☐ HEART STINTS
- ☐ HEPATITIS A
- ☐ HEPATITIS B
- ☐ HEPATITIS C

DO YOU TAKE ANY OF THE FOLLOWING:
PLEASE CHECK ALL THAT APPLY

- ☐ VITAMIN E
- ☐ VITAMIN K
- ☐ BLOOD THINNERS
- ☐ HIGH DOSE ASPIRIN

PRIOR SURGERY INFORMATION

PLEASE LIST ANY PRIOR SURGERIES OR CONDITIONS FOR WHICH YOU WERE HOSPITALIZED

1. _____
2. _____
3. _____
4. _____
5. _____

HAVE YOU HAD COMPLICATIONS FROM SURGERY OR ANESTHESIA? IF YES, EXPLAIN:

_____

_____

_____

FAMILY HISTORY

PLEASE CHECK THE BOX NEXT TO ANY CONDITION A BLOOD RELATIVE OR SPOUSE HAS HAD

SPOUSE	RELATIVE	
☐	☐	DIABETES
TYPE: _____		
☐	☐	CANCER
TYPE: _____		
☐	☐	HEART DISEASE
☐	☐	RHEUMATOID ARTHRITIS
☐	☐	TUBERCULOSIS
☐	☐	EPILEPSY

SOCIAL HISTORY

HAVE YOU EVER TRAVELED OUT OF THE USA? ◯ YES / ◯ NO

DO YOU SMOKE? ◯ YES / ◯ NO

HOW LONG: _____

PACKS PER DAY: _____

DO YOU CHEW TOBACCO? ◯ YES / ◯ NO

DO YOU DRINK ALCOHOL? ◯ YES / ◯ NO

- ☐ MINIMAL
- ☐ MODERATE
- ☐ HEAVY

I have completed this information to the best of my knowledge. I understand that withholding any information or falsifying information may result in serious consequences of my health. I give my full permission to Dr. Apurva Dalal and Tri-State Orthopaedics, LLC to render me care or give their recommendations in my treatment.

I understand that it is ultimately my responsibility to understand all recommendations and follow through with them such as referrals, investigations, follow ups, surgery, physical therapy, etc. I understand that it is my responsibility to call back and make my follow up appointments and appointments for physical therapy, to see other physicians, etc. I hold Dr. Apurva R. Dalal and Tri-State Orthopaedics, LLC and their employees completely harmless for giving me their opinion regarding surgery or any other form of treatment.

_____ _____ _____

PATIENT / GUARDIAN SIGNATURE DATE PATIENT INITIALS

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MEDICAL RECORDS RELEASE AND REQUEST AUTHORIZATION

Your medical record at Tri-State Orthopaedics is a confidential, legal document. Any physician to whom you are referred by Tri-State Orthopaedics will need this record. The record is often needed by your insurance company to approve services. The pertinent information from the record will be released to your insurance company or the organization responsible for the cost of your care and treatment for authorization and/or payment.

I authorize Tri-State Orthopaedics to disclose, discuss and release medical record information including, but not limited to: diagnosis, radiographs (x-rays), radiology reports, treatment, special procedures and prognosis. I understand that pertinent information will be shared only as necessary and only to individuals and/or organizations having appropriate medical, legal and financial concerns related to my care and treatment. I understand that medical record information will not be released or disclosed to family members, spouses, employers (except in workman's comp cases), or any other person not directly involved in my care. I hereby discharge and release Tri-State Orthopaedics and its employees from any responsibility and liability arising out of the disclosure of my medical record to the aforementioned individuals and/or organizations.

I furthermore authorize Tri-State Orthopaedics to request medical record information from any source directly related to my medical history or to the condition for which I am being treated by Tri-State Orthopaedics.

CONSENT FOR MEDICAL TREATMENT

I hereby authorize Apurva R. Dalal, M.D. or persons under his supervision to render the evaluation and medical treatment needed. I further authorize the use of x-rays, injections, casting, bracing, or other diagnostic tests and treatment as determined necessary by my health care provider.

_____ DATE: _____
PATIENT SIGNATURE

_____ DOB: _____
PATIENT PRINTED NAME

SSN: _____

_____
PATIENT ADDRESS

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TRI-STATE ORTHOPAEDICS PATIENT/RESPONSIBLE PARTY FINANCIAL POLICIES

In order to establish a complete understanding of the financial responsibilities associated with the care provided by TRI-STATE ORTHOPAEDICS, the financial policies outlined herein are provided for your review. If you have any questions about these, please feel free to ask our Patient Account Representative for clarification.

It is our desire that you receive the maximum benefit possible from your health insurance. In order to achieve this, we need your assistance in providing complete and accurate personal and insurance information requested on our Patient Registration form. Please complete this form in its entirety and provide your insurance card to be copied.

For patients for whom we have verified health insurance coverage, with an insurance plan with which we participate, we will submit a claim to your insurance company, but require payment of any unpaid deductible, co-payments and coinsurance for services provided in the office at the time services are rendered. In the event your insurance company subsequently denies payment for services provided by TRI-STATE ORTHOPAEDICS, the responsibility for full payment rests with the patient or responsible party. For patients without verified health insurance, or with a plan with which we do not participate, we require a payment in full at the time services are rendered. We accept cash, money orders, and credit cards, **NO CHECKS.**

For outpatient or inpatient surgical procedures, we require payment of the unpaid deductible and applicable coinsurance and co-payments, prior to the surgery. For surgical services covered by your health insurance, we will submit a claim to your insurance company; once the insurance has processed the claim, the patient or guarantor is responsible for any remaining balance. Any services not covered by insurance are to be paid in full prior to surgery.

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements for the plans. Within the same insurance company, plans may differ depending upon the type of contract your employer negotiated. Providing quality medical care for our patients is our primary concern and we are more than willing to provide that care within your insurance contract guidelines; if you inform us at the time of service exactly what guidelines apply. Oftentimes pre-approval or pre-certification for certain services or goods is required: accordingly, there may be a delay or wait time if we are unable to obtain approval from your insurance company immediately. If you do not inform us of any special requirements in your contract and we subsequently order services, such as x-rays, medical supplies or equipments, which are not covered, we will bill you directly for those charges; payment is then your responsibility.

We ask you to assume responsibility for informing us if your coverage has any special requirements, such as pre-certification for hospital admission or surgery, second surgical opinion, or a referral form your primary care physician (PCP). If a referral is required under your insurance plan, it is the patient's responsibility to obtain the necessary approvals. We will be pleased to assist in providing clinical information to primary care physicians upon request, but ask that you obtain all necessary referrals in advance of your scheduled appointment.

Unless we have signed a participating provider similar agreement with the insurance carrier, any charges not covered in full are payable by patient/guarantor. We ask you to remember that the ultimate responsibility for full payment including any collection fees or late charges for your services rests with the adult patient or guarantor. **IN THE EVENT OF DEFAULT, PATIENT EXPRESSLY AGREES TO PAY ALL EXPENSES INCURRED BY TRI-STATE ORTHOPAEDICS IN THE COLLECTION OF MONIES DUE TO TRI-STATE ORTHOPAEDICS PER THIS AGREEMENT INCLUDING BUT NOT LIMITED TO COLLECTION AGENCY FEE, ATTORNEY'S FEES, AND COURT COSTS.**

I have read and understand the financial policy and agree to accept responsibility as described herein.

DATE: _____

SIGNATURE OF RESPONSIBLE PARTY

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D._____** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D._____** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D._____** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D._____** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D._____** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D._____** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

TRISTATE
Orthopaedics and Robotic Surgery

Patient Information Sheet Info

In the event that your account is placed with a Collection Agency, a collection-fee of up to 33.3% may be added to your account and shall become a part of the Total Amount Due. You will be responsible for any and all reasonable collection fees including collection fees, reasonable attorney fees and court cost.

You agree, that in order for us to service your account or to collect any amounts you may owe, we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Patient_____
Date_____