

**Welcome to the offices of
Dr A. S. Martin and Dr M. Milligan**
Please Complete Entirely

PATIENT INFORMATION

Today's Date _____

LAST NAME :		FIRST NAME:	M.I.	DOB:
AGE:	SEX (CIRCLE) MALE FEMALE	SOCIAL SECURITY #	MARITAL STATUS MARRIED SINGLE DIVORCED WIDOWED	
STREET ADDRESS		CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)		CITY	STATE	ZIP CODE
HOME PHONE NUMBER		WORK NUMBER	CELL NUMBER	
EMAIL ADDRESS:				

PATIENT OR RESPONSIBLE PARTY'S EMPLOYMENT INFORMATION

EMPLOYERS NAME	OCCUPATION	WORK NUMBER		
ADDRESS	CITY	STATE	ZIP CODE	

PRIMARY CARE PHYSICIAN

DOCTORS NAME	PHONE NUMBER
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REFERRING PHYSICIAN

DOCTORS NAME	PHONE NUMBER
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REFERRED BY

INSURANCE PROVIDER LIST	YELLOW PAGES	POSTCARD	MAGAZINE	FRIEND/RELATIVE	OTHER
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SPOUSE OR PARENT INFORMATION

LAST NAME :		FIRST NAME:	M.I.	DOB:
SEX (CIRCLE) MALE FEMALE	SOCIAL SECURITY #	RELATIONSHIP TO PATIENT		
STREET ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE NUMBER		WORK NUMBER	CELL NUMBER	

EMERGENCY NOTIFICATION

NAME OF PERSON TO CONTACT	RELATION TO PATIENT	PHONE NUMBER		
STREET ADDRESS	CITY	STATE	ZIP CODE	

Part of body being seen for: _____ Left _____ Right _____

How/When did your pain begin? _____

Is this the result of an injury? YES /NO How did injury happen? _____

If yes, did it happen at work? YES /NO

Do you have an open claim? YES / NO

Do you have an Attorney ? YES /NO

Do have a denial letter from insurance? YES / NO

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
NAME OF INSURED	RELATIONSHIP TO PATIENT	SS #	DOB
MEMBER NUMBER		GROUP NUMBER	

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
NAME OF INSURED	RELATIONSHIP TO PATIENT	SS #	DOB
MEMBER NUMBER		GROUP NUMBER	

THIRD INSURANCE INFORMATION

NAME OF INSURANCE COMPANY		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
NAME OF INSURED	RELATIONSHIP TO PATIENT	SS #	DOB
MEMBER NUMBER		GROUP NUMBER	

WORK RELATED INJURIES ONLY

DATE OF INJURY	WORKERS COMP CARRIER	ADJUSTER	PHONE
HAVE YOU COMPLETED AN EMPLOYER'S C-3 FORM?		HAVE YOU COMPLETED A DOCTOR'S C-4 FORM?	
HOW WERE YOU INJURED?			

AUTO INJURIES - THIS OFFICE DOES NOT ACCEPT AUTO MED PAY OR ATTORNEY LIENS

HAVE YOU NOTIFIED YOUR INSURANCE COMPANY?	DATE OF AUTO ACCIDENT
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MEDICAL HISTORY**ALL QUESTIONS MUST BE ANSWERED**

PRESCRIBED MEDICATION: OVER THE COUNTER MEDICATION & OR SUPPLEMENTS	DOSE:	REASON FOR MEDICATION	SIDE EFFECTS

ALLERGIES:

FEMALE PATIENTS

ARE YOU PREGNANT? YES / NO	ARE YOU TRYING TO GET PREGNANT YES / NO
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REVIEW OF SYSTEMS

ARE YOU CURRENTLY OR HAVE YOU EVER HAD PROBLEMS WITH YOUR: DESCRIBE ALL YES RESPONSES

EYES	YES	NO	
EARS, NOSE, THROAT			
LUNGS, BREATHING			
DIGESTION			
BOWEL MOVEMENT			
BLADDER PROBLEMS			
DIABETES			
HIGH BLOOD PRESSURE			
HEART DISEASE			
BLEEDING PROBLEMS			
BALANCE PROBLEMS			
NUMBNESS / TINGLING			
BLACKOUT/ FAINTING			
PSYCHOLOGICAL PROBLEMS			
AIDS/HIV			
CANCER			
ARTHRITIS			
POLIO			
TB			
EPILEPSY			
KIDNEY FAILURE			

PAST MEDICAL HISTORY

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia? YES / NO Have any problems with anesthesia? YES / NO

Describe any problems : _____

SOCIAL HISTORY
 Work in the home Employed (occupation)_____ Student Retired

 Children? NO YES #____ Do you live alone? NO YES

 Exercise? Daily Weekly Monthly Rarely Never What type_____

 History of substance abuse? NO YES What?_____

 Smoke currently? NO YES ____Packs per day for ____years.

 Quit smoking? This year >1year >5years >10years ____ Packs per day for
 ____years.

 Drink alcohol? Daily # of drinks____ 1-2 x/week 1-2 x/month 1-2 x/year Never

Dr A. S. Martin and Dr M. Milligan

COLLECTION POLICY

I, _____ hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/legal fees that may be added to my account.

Returned checks: A \$25.00 NSF fee will be charged for checks initially returned unpaid by your bank. If the same check is returned a second time, I understand that my account may be referred to a collection service for recovery.

I hereby authorize my insurance carrier to pay medical and/or surgical benefits directly to Dr's Martin, Milligan and associated medical providers. I authorize the release any information, acquired in the course of my treatment, needed for this medical insurance claim. A photocopy of this authorization is to be considered as valid as the original until revoked by me in writing. I understand that I am financially responsible for all charges made to my account whether or not an insurance company, attorney or other third party payor is involved with payment. I am responsible for all co-payment and co-insurance amounts, non-covered supplies and services, and yearly deductibles. Payment for service is expected at the time services are rendered. Doctors and associated medical providers are Preferred Providers of your insurance carrier, we are required by your insurance company to collect your financial portion at the time services are rendered. I agree to pay for all services rendered. Returned check fees are \$25.00 per return. If a collection agency's services are required, I further agree to pay \$25 processing fee. I further agree to pay for all legal fees, court cost and reasonable attorney fees. I understand that any and all fees incurred for medical treatment are my total and ultimate responsibility, regardless of any insurance I may have. In the event that my insurance does not provide benefits or provide reduced benefits and I do not provide my insurance company needed information in a timely manner, I will be financially responsible to pay up to the agreed upon fee schedule.

ACKNOWLEDGEMENT OF PRIVACY POLICIES FOR AS MARTIN ORTHOPEDICS

I hereby acknowledge that I have been presented the Notice of Privacy Practices, or asked for a copy to review.

I have no additional questions and understand the policies in place for privacy.

Signature of Patient or Responsible Party _____ Date _____

Reviewed By Dr. _____ Date _____