Patient Name: ____________________ DOB: ____________________

Medications List

<u>Allergies</u>

____________________ ____________________
____________________ ____________________

Please list any medications you are currently taking

Drug Name	Dosage	Directions	Reason Taking

Preferred Pharmacy:____________________ Date:____________
Location/Number:____________________

New Patient Background Information – Dr. Atul Chandoke

Name: ____

Date of Birth: ______________

Primary reason you are coming into the office today: __________________

____

Referring Doctor: __________________________________

Primary Care Doctor: ___________________________

Additional doctors to whom you would like us to send notes to: __________

____

Previous Tests: (please check)

___ MRI _____X-Rays _____ CT Scan _____EMG/NCV

___ Other (specify) _____________________________

Previous Treatments: (please check)

___ Epidural Injections ___ Trigger Point Injections ___ Tens Unit

___ Chiropractor ___ Radiofrequency ___ Psychologist

___ Physical Therapy ___ Massage Therapy ___ Other (specify)

____

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Detailed Patient History

Name: ________________________ DOB: ______________ Age: ________

Chief Complaint: ____

Was this due to an accident? ___yes___no.   Date of Accident:________

Did this occur while at work? ____ yes ____ no.

Has this problem been treated before? ___yes ___no.

If yes, when and by whom? ____

Current Weight __________ 1 year ago ________ Height: _______ BP: _________

Gender: _________ Race: _________ Marital Status: _________________

Occupation: ____

Do you smoke: _________ If yes, how many per day? _______ How long? __________

Do you consume alcohol? ___________ If yes, how much per week? ______________

Do you consume caffeine? ________ If yes, how much? _________________________

Have you ever received treatment for substance abuse? _____________

If yes, when and where? ____

Have you ever received treatment for alcohol abuse? ________________

If yes, when and where? ____

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Name: ______________________________ DOB: __________

We will be discussing your primary reasons for being referred to us in detail. It is helpful to understand any additional symptoms you are currently experiencing.

Please check off any of the following symptoms you are having:

____ Abdominal Pain

____ Anxiety

____ Chest Pain

____ Constipation

____ Depression

____ Diarrhea

____ Difficulties with sexual function/intercourse

____ Excessive cough

____ Excessive weight gain

____ Excessive weight loss

____ Hearing loss

____ Insomnia

____ Nausea/vomiting

____ Rash

____ Ringing in ears

____ Unexplained fever (outside of an illness such and cold or flu)

____ Vision loss

For women only:

_____ Extremely painful menstrual cycles

____ Irregular cycles Date of last menstrual cycle ________________

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Name: ______________________________________ DOB: ______________

Have you or any of your immediate family members had any of the following?

___ **Heart Disease** ___self ___ mother ___father ____other

___ **High Blood Pressure** ___self ___mother___ father ____other

___ **Stroke** ___ self ____mother _____father ____ other

___ **Cancer** ___ self ____mother _____ father ____other

___ **Glaucoma** ____self ____mother _____father ____other

___ **Diabetes** ____self ____mother _____father ____ other

___ **Epilepsy/Seizures** ____ self _____mother _____father ____other

___ **Bleeding Disorder** ____self ____mother _____father ____other

___ **Thyroid Disease** ____self ____mother ____father ____other

___ **Mental Illness** _____self ____mother ____father ____other

___ **Osteoporosis** ____self ____mother ___father ____other

___ **Tuberculosis** ____self ____mother ____father ____other

___ **Kidney Disease** ____self ____mother _____father ___other

___ **Other** ____self ____mother _____father ____other

Please list all previous surgical procedures:

____

____

____

____

____

Patient Signature: ________________________________ Date: ______________

Reviewed by: __________________________ Date: _____________________

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided with and understand this facility's Notice of Privacy Practices (HIPAA information). This notice provides a complete description of the uses and disclosures of my health information.

Patient Name: ___________________________________ Date of birth: ___________________________

____ _______________________________________

*Patient or Representative Signature Date

____ _______________________________________

Name of Personal Representative (if applicable) Relationship to Patient (ex: parent, power of attorney)

**If the patient is a minor child or otherwise unable to sign this authorization, then obtain the signature of the authorized individual. If person is POA, we must have a copy of the Power of Attorney paperwork.*

Consent to Be Contacted

Beacon Orthopaedics & Sports Medicine, or third parties on our behalf, may need to contact you regarding your healthcare or your account with us. Those communications may include appointment and exam confirmation and reminders, wellness checkups, pre-registration instructions, pre-operative instructions, post-discharge instructions, post-appointment follow-up, prescription notifications, and other messages relating to your care, scheduling, benefits, billing, payment, or other financial responsibilities. By providing your phone number, you agree to receive calls or text messages from Beacon Orthopaedics & Sports Medicine, or a third party on its behalf, at the number you have provided. Such calls may be placed using an automatic telephone dialing system.

Please provide your preferred contact information below.

Name: _____________________________________

Cell Phone Number: __________________________ Home Phone Number: __________________________

☐ I would like to receive emails from Beacon Orthopaedics & Sports Medicine regarding new services, educational content, events, and other content related to orthopaedic conditions/treatment options.

Email Address: ____

Beacon Orthopaedics and Sports Medicine, LLC Financial/Credit Policy
Effective April 2009

Patient Name: ______________________________ **Patient Date of Birth:** ______________________
Please Print

Beacon Orthopaedics and Sports Medicine, LLC (BOSM) believes that in the interest of good health care practices, it is best to establish a patient financial/credit policy between our patients and ourselves in order to avoid any misunderstandings. Our Account Representatives will be glad to discuss your account with you at any time and set up payment plans. Our primary responsibility is to deliver quality health care services. We wish to spend our time and energy toward that responsibility. We expect you to show us the same consideration as you do your other creditors, and to be honest and forthright regarding your financial responsibility.

(PLEASE INITIAL THE FOLLOWING)

_____1.) **We expect that all co-pays, co-insurance and deductible be paid in full at each visit and prior to surgery, diagnostic testing and physical therapy.** We accept cash, check, Debit Card, MasterCard, VISA, American Express, Discover and Care Credit.

_____ 2.) **We file claims to your insurance company for your primary and secondary policies**. You must bring your insurance card with you to every visit and make us aware of any change in coverage. We also require a copy of your driver's license to confirm identity. Please remember insurance coverage is a contract between the patient and the insurance company. When BOSM files for benefit for services performed, benefits are assigned to BOSM. BOSM will look to the patient for payment in full if insurance does not cover the services provided. If we do not participate with your insurance, you will likely have a higher out-of-pocket expense, so please be prepared to pay this amount.

_____3.) ***We do not file any insurance with your Automobile Insurance Company, or any other third party (business insurance company, employer, attorney, separated spouses, etc.) for the purpose of obtaining payment.*** We will make every effort to provide you with proper documentation for you to receive reimbursement from those parties (i.e., claim form, statement or report). Please speak with our billing representative. We do not accept Letters of Guarantee or other promises to pay when cases settle. You will be extended credit only if arrangements are made in advance and only within our standard guidelines for credit.

_____4.) **If the patient is under age 18, a parent or guardian must sign below**. If the minor does not reside with both parents, and there is a dispute over which parent is responsible for any remaining balances, we will ultimately rely upon the parent/guardian who brought the child to the office for financial responsibility. All minors will not be seen unless accompanied by a guardian or a signed authorization from that guardian allowing our physicians to provide medical treatment.

_____5.) **A service charge of $20.00 will be applied to returned checks**. You will be asked to bring cash, money order or cashiers check to our office to cover the amount of the check plus the service charge. If you present two (2) checks that are returned to us, we will require cash for future services.

_____6.) **If your balance is not paid in a timely manner, we reserve the right to forward your account to an outside collection agency or attorney.** All fees assessed by the agency or attorney will be charged to you and become a part of your outstanding balance.

By signing this agreement, you are acknowledging that you understand our financial/credit policy, and agree to pay for all services that are received.

Name - Person Completing Form (Print): ____________________________________ Birthdate of Person: __________________

Signature - Person Completing Form: ____ Date: ______________________________