

## SIGNATURE ORTHOPEDICS

Date: \_\_\_\_\_  New Patient  Update

Referred to this Office by:  Patient  Physician  ER (Hospital) Name of Person/Hospital: \_\_\_\_\_

Patient's name (Last, First MI) \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_

Patient Email \_\_\_\_\_ SSN \_\_\_\_\_ Marital Status \_\_\_\_ Spouse's Name \_\_\_\_\_

Patient Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

### PARTY RESPONSIBLE FOR BILL (AND SPOUSE) IF OTHER THAN PATIENT

Both Parents, if patient is a minor (under 21)

Name (Last, First MI) \_\_\_\_\_ Relationship \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_ Work # \_\_\_\_\_

Employer's name \_\_\_\_\_ Employers Address \_\_\_\_\_

Name (Last, First MI) \_\_\_\_\_ Relationship \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_ Work # \_\_\_\_\_

Employer's name \_\_\_\_\_ Employers Address \_\_\_\_\_

### INSURANCE INFORMATION: PLEASE HAVE INSURANCE CARD(S) AVAILABLE TO COPY

**Primary Insurance** \_\_\_\_\_ Effective Date \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Full Name \_\_\_\_\_ Subscriber SSN \_\_\_\_\_ DOB \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ Effective Date \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Full Name \_\_\_\_\_ Subscriber SSN \_\_\_\_\_ DOB \_\_\_\_\_

**Other Insurance** \_\_\_\_\_ Effective Date \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Full Name \_\_\_\_\_ Subscriber SSN \_\_\_\_\_ DOB \_\_\_\_\_

### INJURY REPORT/NATURE OF INJURY

Worker's Comp  Recreational  Auto  Home  Other  Date of Injury \_\_\_\_\_

**SIGNATURE ORTHOPEDICS - SIGNATURE MEDICAL GROUP**  
**PATIENT REGISTRATION CONSENT & ACKNOWLEDGMENTS**

**CONSENT TO TREAT**

I consent to Signature Medical Group (SMG) physicians, practitioners, and other providers ("provider"), their assistants and staff to provide medical and/or surgical treatment, testing, supplies, medications, services, equipment and other items deemed necessary for the patient below. I have been informed of the nature and purpose of the proposed treatment, common side effects, risks, benefits, alternatives and estimated duration of treatment as applicable. I understand that I may withdraw consent to treatment and will inform the attending Provider of any decision to terminate treatment. I agree to provide at least 24 hours notice prior to canceling an appointment and understand that failure to provide notice may result in a cancellation fee. In the event of an emergency while receiving care at SMG, I authorize SMG staff to arrange for care and treatment necessary to address the emergency medical condition.

**ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY**

I acknowledge that the patient or guarantor signing below is financially responsible for all charges for medical services provided by SMG and payment is due on the date of service. If an insurance/health plan claim is filed by SMG, I request that payment of all benefits be made directly to SMG. I agree to pay for any services or out-of-pocket expenses which are not covered by insurance. I acknowledge receipt and acceptance of SMG's Payment Policies provided with this form. I acknowledge that I will be responsible for payment of legal and collection fees in addition to the outstanding balance should SMG refer my account to an outside agency for collection.

**RELEASE OF INFORMATION/DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I consent to SMG's release of the patient's protected health information (PHI) for treatment, payment and operations purposes in accordance with HIPAA. I acknowledge that SMG may release medical records and PHI to the third-party health plan or payer, including Medicare, Medicaid, health insurer, HMO, or other company or program that arranges or pays for the cost of some or all of the patient's health care. SMG may also release PHI to other health care providers involved in treating the patient including physicians, hospitals, laboratories, pharmacies and others. I have been provided with SMG's Notice of Privacy Practices that further describes the uses and disclosures of certain PHI by SMG. To facilitate treatment or payment, including communication of appointment reminders, prescriptions/refills, laboratory results and other information, I consent to SMG sharing PHI with the following individuals:

Full Name _____	Relationship _____	Phone # _____
Full Name _____	Relationship _____	Phone # _____
Full Name _____	Relationship _____	Phone # _____

Initial all applicable information:

- Medical/Treatment/PHI including retrieval of medical records and prescription refills
- Lab/Ancillary Testing/Radiology/MRI/Imaging Results
- Billing/Insurance Information
- Authorized to leave message on voicemail or by other designated communication systems
- Other, Describe \_\_\_\_\_

**ADVANCE DIRECTIVES FOR HEALTH CARE** *(Living Will/Healthcare Directive, Durable Power of Attorney for Healthcare)*  
*(If applicable to the practice setting, patient to initial appropriate statement):*

- The patient does NOT have an Advance Directive
- The patient has the following Advance Directive(s): \_\_\_\_\_

and will provide a copy to the attending SMG physician practice

.....

Print Patient's Full Name \_\_\_\_\_ Patient DOB \_\_\_\_\_

Print Name of Legal Guardian \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Signature & Date Signed \_\_\_\_\_ Witness to Signature \_\_\_\_\_

# PAYMENT POLICIES SIGNATURE MEDICAL GROUP

We accept cash, check, debit, Visa, MasterCard and most health plans/insurance programs. You may consent to automated payment card payments by signing a separate authorization.

If the patient is covered by insurance, the following apply:

1. The patient/responsible party or guarantor signing below (“you”) must provide us with the patient’s current and correct medical coverage/insurance/health plan (“health plan”) or other responsible third-party payor.
2. You must follow the rules of the health plan such as providing a valid referral form and precertification of testing and/or surgery when required by the health plan for payment. We will assist with this process, but if claims are denied because of your failure to comply with coverage/payment rules, you will be responsible for paying the denied claim(s).
3. You are responsible for paying any deductibles, co-payments, non-covered services or other costs not covered by the health plan.
4. Co-payments, non-covered services and other point of service payments must be paid at the time of service including amounts due for a child regardless of parental custody, divorce or separation terms.
5. **WORK RELATED INJURIES:**
  - a. If the patient’s employer has approved treatment, you will not be charged or billed.
  - b. If the patient’s employer does not approve treatment and YOU SELECT US FOR YOUR TREATMENT, you may be billed and you may be responsible for payment of services not approved by the employer.
6. If the patient is involved in a claim or lawsuit that affects the payment of our services, we hold you responsible for payment of our regular fees.
7. We file group health plan claims and by law, must file Medicare claims.
8. If you think your bill contains an error or if you need more information about an item on your bill, contact us at the address or telephone number on your bill.

We expect payment in full at time of service for all charges which are not covered by the patient’s health plan. It is your responsibility to contact us in the event of a need for an alternative payment plan or to apply for a discount if you do not have insurance.

In the event of non-payment, you will be responsible for any legal and collections fees. Legal and collection fees will be added to the outstanding balance on the account should the account be referred to an outside agency for collection.

I have read and agree to the above terms and hereby assume full responsibility for paying any medical service charges and collection fees according to these terms.

Print Patient Name: \_\_\_\_\_/Date of Birth: \_\_\_\_\_

Print Guarantor Name & Relationship to Patient: \_\_\_\_\_

Signed: \_\_\_\_\_/Date: \_\_\_\_\_  
Patient or Guarantor/Responsible Party, if other than Patient

(Witness to Signature, if applicable): \_\_\_\_\_

# SIGNATURE ORTHOPEDICS

## INITIAL MEDICAL EVALUATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Which is your dominant hand?  Right  Left Gender:  Male  Female Height \_\_\_\_\_ Weight \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Language: \_\_\_\_\_

Work status: (check one)  Working  Retired  Student  Disabled  Other \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Who referred you to our clinic?  Self  Friend  Physician Name: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Cardiologist: \_\_\_\_\_

**Reason for Visit/Chief Complaint:** Please describe injury/complaint and how long condition has been present:

\_\_\_\_\_

\_\_\_\_\_

Date of onset injury/symptom \_\_\_\_\_ Is this work related?  YES  NO Has it been reported?  YES  NO

Have any x-rays or tests been performed  YES  NO Date \_\_\_\_\_ Facility Name \_\_\_\_\_

Name of tests: \_\_\_\_\_

### Past Medical History (Please check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Alzheimer's Disease        | <input type="checkbox"/> High Cholesterol                     |
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Fibromyalgia                         |
| <input type="checkbox"/> Angina                     | <input type="checkbox"/> Fracture                             |
| <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Gout                                 |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Headache/Migraine                    |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Hepatitis/liver disease              |
| Specify type: _____                                 | <input type="checkbox"/> HIV                                  |
| <input type="checkbox"/> Congestive Heart Failure   | <input type="checkbox"/> High Blood Pressure                  |
| <input type="checkbox"/> COPD                       | <input type="checkbox"/> Inflammatory bowel disease           |
| <input type="checkbox"/> Crohn's disease            | <input type="checkbox"/> Lyme disease                         |
| <input type="checkbox"/> Coronary Artery disease    | <input type="checkbox"/> Myocardial infarction (heart attack) |
| <input type="checkbox"/> Deep Vein Thrombosis (DVT) | <input type="checkbox"/> Obesity                              |
| <input type="checkbox"/> Degenerative joint disease | <input type="checkbox"/> Osteoporosis                         |
| <input type="checkbox"/> Depression                 | <input type="checkbox"/> Peptic Ulcer disease                 |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Psoriasis                            |
| <input type="checkbox"/> Drug Abuse                 | <input type="checkbox"/> Renal disease (kidney disease)       |

### NO PAST MEDICAL HISTORY

- Seizure disorder
- Sleep Apnea
- Spinal Stenosis
- Spondyloarthopathy (Spondyloarthritis)
- Stroke
- Systemic lupus erythematosus (Lupus)
- Thyroid disease
- Vascular disease
- Other Medical Problems:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list the name of the physician who is treating you for any of the following conditions: Diabetes, peripheral neuropathy, atherosclerosis of the arteries in your extremities, Buerger's disease, cardiology or chronic thrombophlebitis.

Name \_\_\_\_\_ Location \_\_\_\_\_ Date last seen \_\_\_\_\_

**Past Surgical History** (Please specify TYPE of surgery, DATE of surgery, side, etc.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**History of MRSA or MSSA:** Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, where on body \_\_\_\_\_

**Current Medications & dosage** (if known):  NO Medications *If you brought a list, please ask us to make a copy.*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies:** (Please name substance and reaction)  NO Known Allergies

Known DRUG allergies \_\_\_\_\_

Known FOOD allergies \_\_\_\_\_

Known METAL allergy:  Yes  No Known LATEX allergy:  Yes  No

**Relevant Family History:** **Adopted - no family history known**

Relative	Alive	Deceased	Heart Disease	Cancer (Specify type)	Diabetes	High Blood Pressure	Renal disease	Thyroid disease
Father								
Mother								
Brother(s)								
Sister(s)								
Maternal Grandfather								
Maternal Grandmother								
Paternal Grandfather								
Paternal Grandmother								

**Social History:**General Education:  High School (If local, list name) \_\_\_\_\_  College \_\_\_\_\_ Post graduate or other \_\_\_\_\_Marital Status:  Single  Married  Separated  Divorced  WidowedTobacco use:  Yes  No \_\_\_\_\_ Packs per day for \_\_\_\_\_ years Quit:  Yes  No Age when quit: \_\_\_\_\_Alcohol use:  Yes  No Frequency/Amount: \_\_\_\_\_

Other substance use: \_\_\_\_\_

Work demands:  Sedentary  Moderate activity  Heavy LaborDo you exercise regularly?  Yes  No Describe: \_\_\_\_\_

What sports or activities do you participate in? \_\_\_\_\_

**PATIENTS 65 YEARS AND OLDER:**Have you had any falls in the last year?  Yes  No *IF YES*, Number of falls: \_\_\_\_\_Did the fall(s) result in injury?  Yes  No *IF YES*, Details: \_\_\_\_\_

Do you use an assistive device (walker, cane, wheelchair, etc.)? \_\_\_\_\_

Have you ever received a Pneumonia vaccine?  Yes  No *IF YES*, what month/year? \_\_\_\_\_**Current Medical Status/Review of Systems: Please circle any you have had recently**

Fatigue	Chest Pain	Poor coordination
Fever	Leg swelling	Muscle weakness
Night sweats	Irregular heartbeat	Seizures
Weight gain	Constipation	Tremors
Weight loss	Diarrhea	Anxiety
Blurred vision	Loss of Appetite	Depression
Double vision	Nausea	Insomnia
Headache	Vomiting	Rash
Ringing in ears	Painful urination	Skin Infections
Vertigo	Blood in urine	Skin lesions
Vision loss	Cold intolerant	Bleeding
Asthma	Heat intolerant	Bruising
Cough	Difficulty walking	Environmental allergies
Labored breathing	Dizziness	Food allergies

Pharmacy Name: \_\_\_\_\_ Pharmacy Ph#: \_\_\_\_\_

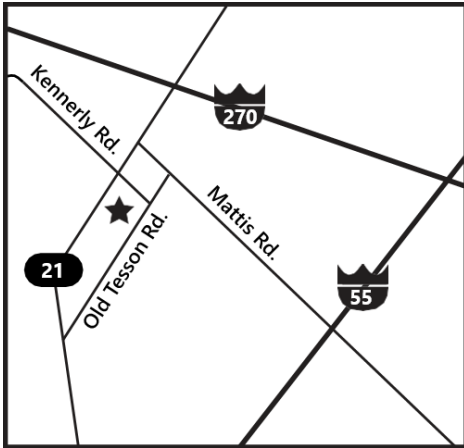
D\ Ufa UWn5 XXfYgg. 'SS'

Name of person supplying information \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_



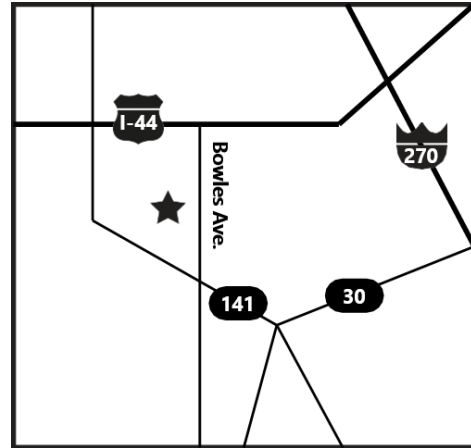
# SIGNATURE ORTHOPEDICS



## South County

12639 Old Tesson Rd., Suites 100 & 115  
St. Louis, MO 63128  
**314-849-0311**

If you are traveling south on I-270, exit on Tesson Ferry Road and turn right. Drive 2 lights to Kennerly Road and turn left. Go one block to the stop sign and turn right onto Old Tesson Road.



## Fenton

1011 Bowles Ave., Suite 100  
Fenton, MO 63026  
**314-849-0311**

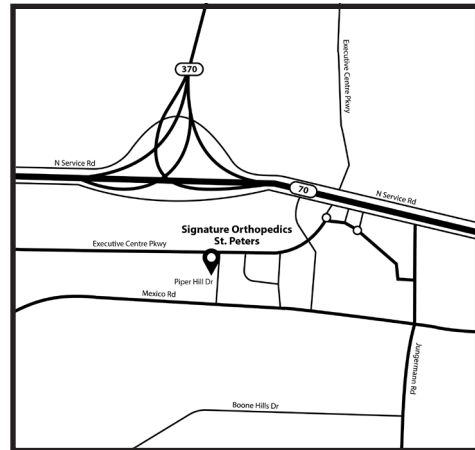
If you are traveling east on I-270 S, exit I-44/US-50 W, exit #274A. Merge onto I-44/US-50 W, and take the Bowles Avenue exit and turn left onto Bowles Avenue at the first stoplight. After turning left, stay on Bowles Avenue until you see SSM St. Clare hospital on the right. Turn right, pass the emergency room and continue on the road until you see the St. Francis building. There is a free parking lot in front of the St. Francis building. Once you walk into the St. Francis building, we are the Suite 100 on the right.



## O'Fallon

9323 Phoenix Village Pkwy.  
O'Fallon, MO 63368  
**636-561-0871**

If you are traveling west on I-64/US-40, exit at Winghaven Boulevard, exit 6. Turn north, or right, onto Winghaven Boulevard and go to the third stoplight and turn right onto Phoenix Parkway, which is just past Hammock Court. Take the first right onto Phoenix Village Parkway and the office will be on your left.



## St. Peters

112 Piper Hill Dr., Suite 6  
St. Peters, MO 63376  
**636-229-5011**

If you are traveling west on I-70, take exit 225 to Cave Springs/Truman Road. Turn left onto Cave Springs Rd. Use right two lanes to turn right onto Mexico Road. Turn right onto Piper Hill Drive. 112 Piper Hill Drive is on the left. The office is located on the second floor.