Peyton Manning Children's Hospital at St.Vincent

PEDIATRIC ORTHOPEDIC SURGEONS OF INDIANA

PATIENT INFORMATION

Name: _____

Sex: _____ DOB: _____ Age: _____

Address: _____

City/State/Zip: _____

Person Responsible for Payment: (Must be parent OR legal guardian of minor child receiving treatment)

Name: _____ DOB: _____

Relationship to Patient: _____ Social Security #: _____

Marital Status: _____ Occupation: _____

Address: _____

City/State/Zip: _____

Home Phone #: _____ Work Phone #: _____

Name of Employer: _____

Employer's Address: _____

Emergency Contact:

Name: _____

Address: _____

City/State/Zip: _____

Home Phone #: _____ Work Phone #: _____

Primary Insurance:

Company: _____

Policy Holder: _____

Policy Holder's DOB: _____

Secondary Insurance:

Company: _____

Policy Holder: _____

Policy Holder's DOB: _____

AUTHORIZATION, ASSIGNMENT & FINANCIAL RESPONSIBILTY

I AUTHORIZE THE P.O.S.I. GROUP AT ST.VINCENT TO FURNISH INFORMATION TO INSURANCE CARRIERS AND OTHER RELATED ENTITIES IN ORDER TO PROCESS CLAIMS ON MY CHILD'S BEHALF. I REQUEST THAT ANY INSURANCE PROCEEDS BE PAID ON MY BEHALF TO THE ST.VINCENT P.O.S.I. GROUP FOR SERVICES PROVIDED TO MYSELF OR MY CHILD, BY THEM. I UNDERSTAND AND ACCEPT FULL RESPONSIBILITY FOR PAYMENT OF SERVICES PROVIDED TO ME BY THE ST.VINCENT P.O.S.I. GROUP NOT COVERED BY INSURANCE. IF, FOR ANY REASON, THE ACCOUNT SHOULD REQUIRE THIRD PARTY COLLECTION, I AGREE TO PAY ALL COURT FEES, LEGAL FEES AND COLLECTION FEE CHARGES.

_____ _____

Signature of Parent/Legal Guardian Date

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VERIFICATION OF INSURANCE BENEFITS

Patient Name: _____ D.O.B. _____

By signing my name below, I am agreeing that:

- The copy of the insurance card presented is current and has the correct insurance information.
- I am still covered under this policy.
- The co-pay listed on the card will be paid at the time of service (unless other arrangements have been made).

If I sign this form and the insurance card is later found to be expired of invalid, I understand that I am responsible for paying for the services in full and filing to the insurance carrier myself.

Signature of parent/responsible party	Date signed
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____

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PHYSICIAN HISTORY

Were you a previous patient of Drs. Bellflower, Didelot or Kayes? _____

Family Physician / Pediatrician

Name: _____

Address: _____

City/State/Zip: _____

Phone #: _____ Fax #: _____

Referring Physician

Name: _____

Address: _____

City/State/Zip: _____

Phone #: _____ Fax #: _____

List the Names of Physicians who should receive copies of office visit notes:

_____

_____

_____

_____

_____

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COMMUNICATION RELEASE

Because of federal privacy regulations, we must have your permission as to where we may leave messages regarding any protected health information.

I authorize the physicians of this practice and/or staff to leave medical information pertaining to the care of my child(ren) by the following methods and will assume responsibility to notify them whenever this information changes. In addition to medical information, information concerning appointment confirmation, rescheduling of appointments or nurse's follow-up may be left by the following methods. ***Please initial each response***

Method	Number (including area code)	Yes	No
Home telephone			
Answering machine			
Work telephone			
Voicemail			
Cell phone			
Pager			
Fax			

The following individuals have my/our permission to receive medical information about my/our children:

Name	Relationship

Your office has my permission to post any pictures that we may send in. YES _____ NO _____

If there are any changes to the above authorizations, it is the parent's responsibility to notify the office of any changes.

Child's Name: _____ D.O.B. _____

Parent/Guardian: _____ Date: _____
(PRINTED)

Parent/Guardian: _____ Date: _____
(SIGNATURE)

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MEDICAL HISTORY

Patient Name: _____Date: _____
D.O.B. _____Age:_____ Gender: _____
Pediatrician _____ Orthopedist_____
Reason for Visit (right/left) _____Date Problem Began_____

Birth Hx

Premature C-Section Breech Problems with pregnancy/labor/delivery: _____
Birth Weight: _____ Age Sat: _____ Age Walked: _____ Age Spoke: _____

Patient's Social History

Lives with: Family / Guardian / Care facility / Group home

Patient's Family History

Back problems / Scoliosis / Neurological problems / Joint problems / Arthritis / Bone deformities / Fibromyalgia

Does your child have any of these problems today?

Fever	Chills	Nausea	Vomiting	Weight Loss
Bleeding Disorder	Fatigue	Visual Problems	Sore throat	Ear Ache
Shortness of Breath	Fast Heart Rate	Irritable bowels	Diarrhea	Weakness
Burning with urination	Night pain	Night sweats	Skin lesions	Joint pain
Joint swelling	Muscle pain	Abnormal gait	Tremors	Numbness

STOP HERE

Height:_____Weight: _____ OFC:_____Age at Menarche: _____

PMH 1. 2. 3.
4. 5. 6.

PSH 1. 2. 3.
4. 5. 6.

MEDS (Rx, herbals, vitamins, over the counter) and reason for taking
1. 2. 3.
4. 5. 6.
7. 8. 9.
10. 11. 12.

Allergies 1. 2. 3.

Pain Assessment: Baker and Wong (FACES) / VAS _____

Treatment: _____ Reassessed Relief / Call if no improvement

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DOCTOR TALK FORM

To make your visit more efficient, please help us with the following:

Please list the 2-3 most important questions that you have for the doctor today.

1. _____

2. _____

3. _____

What forms or excuses will you need before leaving today? **(Please circle)**

School	Work	PE	FMLA
Transportation	Prescriptions	PT	Brace shop

Other: _____