INTEGRITY ORTHOPEDICS **DANIEL WEBER M.D.**

Patient Name ________________________________ **Date of Birth** ______________________
Social Security # ______________________________ **Male**________ **Female** _______ *check one*
Referring Physician ________________________ **Primary Physician** ______________________
Martial Status _____ married _____ single _____ divorced _____widowed *check one*

Nearest Relative in Case of Emergency: *If elderly please put children(s) information here. Name and Phone #*
____

Can we discuss your health and/or records with your spouse, children, etc? YES or NO ________
If yes, please list names and relationship to you. _______________________________________
____

If your mailing address has changed since your last visit OR if you're a new patient, please fill out the following section.
Address _________________________ City ________________ State______ Zip Code_______
Home Phone Number _____________________Cell Phone Number _____________________

If your employer has changed since your last visit OR if you're a new patient, please fill out the following section.
Employer Name ______________________________ Phone Number ____________________
Employment Status _______ Full Time _________ Part Time *check one*

If your spouse's employer has changed since your last visit OR if you're a new patient, please fill out this section.
Employer Name______________________________ Phone Number ____________________
Employment Status ________ Full Time _________ Part Time *check one*

If your insurance information has changed since your last visit OR if you're a new patient, please fill out this section.
Primary Ins. Co. Name ______________________________ Phone Number________________
Policy Number ________________________________ Group Number ___________________
Is this coverage through you, spouse or which parent ____________________________________
Secondary Ins. Co. Name ____________________________ Phone Number _______________
Policy Number ________________________________ Group Number ___________________
Is this coverage through you, spouse or which parent ____________________________________

Worker's Compensation
Date of Injury _________ Claim # _______________ Adjuster/Case Manager________________

Auto Accident
Date of Accident ________ Claim # ______________ Accident State ______________________

I have received the notice of privacy policies from Integrity Orthopedics and authorize the release of any medical information necessary to process this claim. I also give permission to release limited medical information to a family member or caregiver at Integrity's professional discretion.

Patients Signature (parent or guardian if minor) ______________________________________Date________________

I understand that I am financially responsible for all services rendered and I assign, transfer, and set over to the above named doctor all my rights, title, and interest to any medical reimbursement benefits under the above listed insurance policies.

Guarantor Signature____ Date ____________

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Consent to treatment and Release of Information

Unless otherwise directed below, if I am unavailable, Integrity Orthopedics may communicate normal test results via home telephone voice mail or answering machine to the phone numbers on this form, as long as the nature of the test is not disclosed. Check all that apply:

_____ Yes, and in addition, my normal test results may be left on the following answering machine/voice mail

(_______) _______-____________

_____ Yes, and in addition, my normal test results may be communicated to ____________________________ (relationship: ________________________)

_____ No, I want my test results only communicated personally to me

I authorize examination and medical treatment as deemed necessary in the judgment of my physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of any diagnosis, treatment, surgery, test, or examination conducted or performed. I understand that my medical records are protected under federal and state law and may be disclosed without my written consent for purposes of treatment, payment, and healthcare operations. I further understand that the specific type of information to be disclosed may include diagnosis, prognosis, treatment for physical or psychiatric illness, treatment for alcohol or substance abuse, or HIV testing. I acknowledge that I have been offered and received or declined to receive a copy of the HIPAA Notice of Privacy Practices. I authorize verification of medical benefits and benefits to be paid directly to the Physician and I understand that I am responsible for any unpaid balance under the terms of my insurance policy.

THIS AUTHORIZATION REMAINS VALID UNLESS REVOKED BY ME IN WRITING

Signature of patient or legal guardian ____

Date _______/_______/_______

INTEGRITY ORTHOPEDICS **DANIEL WEBER M.D.**

Patient Name: ____Date:_________________

Chief Complaint/ Reason for Visit: ____

Check & list allergies

- ○ Penicillin ○ Iodine
- ○ Aspirin ○ Antibiotics
- ○ Sulfa ○ Novocaine
- ○ Codeine ○ Xylocaine
- ○ Tape ○ None

Other__________________________________

____

List the medications you are currently taking:

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

List any surgeries you have had and give the date:

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

Check the medical conditions you are known to have now or in the past:

○ High blood pressure	○ Convulsions	○ Ulcers	○ Arthritis
○ Kidney/bladder disease	○ Heart trouble	○ Asthma	○ Diabetes
○ Lung trouble	○ Tuberculosis	○ Gout	○ Bleeding problems
○ Blackouts	○ Hepatitis	○ Cancer	○ Osteoporosis

Have you had a Bone density test for Osteoporosis? __________ If yes, when? _______________

If female, are you pregnant? ____________ If yes, give expected delivery date: _______________

List any major illness: ____

Personal and Social History:

Height:____________________ **Weight:_________________**

List your occupation: ____

Do you smoke?____ How much? ___________ Do you drink? _____ How much? _____________

Do you use controlled substances? __________ **Patient's Signature(Parent, if minor):________________________________ Date: _____________**

INTEGRITY ORTHOPEDICS **DANIEL WEBER M.D.**

Medication Log:

Patient Name ______________________________________ **Birthdate** _____________________

Home Phone __________________________ **Work/Cell Phone** _________________________

Pharmacy _______________________________ **Pharmacy Phone** _______________________

Allergies____
____
____

Date	Medication	Qty	Frequency	Refills