Acknowledgement of Receipt of Privacy Notice

Acknowledgement of Receipt of Privacy Notice Effective March 13, 2012. I have been presented with a copy of Mark Endicott M.D. Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information: _____

_____

Signed:_____ Date:_____

Print Name: _____

Please allow the following people access to my Health Information. If do not wish to list anyone, please enter "self only".

I allow the following people access to my Health Information

Signed:_____ Date: _____

1. Name:_____

Relationship_____

2. Name:_____

Relationship_____

3. Name _____

Relationship_____

If at any time you wish to make a change, please ask our staff for another form. Thank you for your cooperation.

MEDICAL HISTORY

NAME: _____

DOB:_____ Height:_____ Weight:_____

Referring Physician:_____ Primary Physician:_____

Describe current problem_____

How long has this problem been present?_____

Were you injured? Yes/No If yes when:_____

How injured: _____

Have you been treated for this problem Y/N_____

If so, who treated you?_____

List any medical problems you are being treated for at the present time, for example high blood pressure, heart disease, diabetes, arthritis or cancer, ect._____

_____

ALLERGIES:_____

Latex Allergy? Yes/No

Current Medications	**Prior Surgeries and/or Hospitalizations**	
	Procedure	Date
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

Mark Endicott M.D.
Orthopedic Surgery

PATIENT_____ BIRTHDATE_____ AGE ____SEX M/F
(LAST) (FIRST) (MI)

MAILING ADDRESS:_____ ZIP CODE_____

RESIDENCE ADDRESS IF DIFFERENT _____ ZIP CODE _____

HOME PHONE #_____CELL #_____WORK #_____ eMAIL _____

EMPLOYER _____OCCUPATION _____

NAME AND PHONE # OF EMERGENCY CONTACT _____

ONLY COMPLETE IF THE FOLLOWING IF PATIENT IS MINOR

FATHER'S NAME:_____ MOTHER'S NAME _____

FATHER'S BIRTHDATE_____ MOTHER'S BIRTHDATE _____

WHAT IS THE REASON FOR YOUR VISIT_____

RIGHT?____LEFT? _____ DATE OF ONSET OR INJURY_____HAVE YOU HAD XRAYS _____

IF SO WHERE WERE THEY TAKEN _____IF INJURY, HOW DID IT HAPPEN? _____

_____

HOW DID YOU HEAR ABOUT US? _____

PRIMARY CARE PHYSICIAN:_____ PHONE:_____

PLEASE PROVIDE INFORMATION IF YOU WOULD LIKE US TO BILL YOUR HEALTH INSURANCE

PRIMARY INSURANCE_____ SECONDARY INSURANCE _____

NAME OF POLICY HOLDER _____ DATE OF BIRTH_____

RELATIONSHIP TO PATIENT _____

PLEASE PRESENT ALL INSURANCE CARDS AND YOUR DRIVERS LICENSE AT CHECK IN

I UNDERSTANDTHAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE PAID BY MEDICAL INSURANCE. I WILL ALSO BE RESPONSIBLE FOR ANY COSTS OF COLLECTIONS OR ATTORNEYS FEES IN THE EVENT THAT THEY ARE NECESSARY. I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL INFORMATION NECESSARY TO SECURE PAYMENT FROM MY MEDICAL INSURANCE CARRIER. I ALSO AUTHORIZE MY INSURANCE CARRIER BY MY SIGNATURE BELOW TO PAY ANY MEDICAL BENEFITS DIRECTLY TO DR. ENDICOTT.

DATE_____**SIGNATURE** _____

MEDICATION INFORMATION RELEASE CONSENT FORM

Our EHR (electronic medical record) system has the capability of obtaining a list of your current medications. This is helpful in providing for your care. We would like your permission to access this information.

_____ I give Dr Endicott authority to access my pharmaceutical records

_____ I do not give Dr Endicott authority to access my pharmaceutical records

Patient (printed)

Name _____ DOB _____

Patient /Guardian

Signature_____ Date_____

PLEASE CIRCLE ANY MEDICAL ISSUES YOU CURRENTLY HAVE OR HAVE BEEN TREATED FOR IN THE PAST

PATIENTS NAME _____ DOB: _____

Anxiety Disorder	**Kidney Stones**
Arthritis	**Leg/Foot Ulcers**
Asthma	**Liver Disease**
Bleeding Disorder	**Organ Transplant**
Blood Clots (DVT)	**Osteoporosis**
Cancer	**Other Lung Disease**
Claustrophobic	**Poliomyelitis**
Coronary Artery Disease	**Peripheral Vascular Disease**
Diabetes	**Pulmonary Embolism**
Dialysis	**Reflux Disease**
Diverticulitis	**Ulcers**
Fibromyalgia	**Stroke**
Gout	**Tuberculosis**
Have A Pacemaker	**Urinary Tract Infection**
Heart Arrhythmia	**OTHER:**
Heart Attack (MI)	
Heart Murmur	
Hiatal Hernia/ Reflux	
HIV or AIDS	
Hypertension/High Blood Pressure	
High Cholesterol	
Thyroid Disease	
Kidney Disease	