GREATER PITTSBURGH ORTHOPAEDIC ASSOCIATES

Patient's Full Name_____ **Birthdate**_____-____-_____ **Age**_____

Height_____ Weight_____

What body part are you seeing the doctor for?_____ RT LT Both

Describe injury/present illness in detail and how long it has been bothering you?

_____

_____

Current problem is the result of a(n):

Car Accident _____ Work Accident_____ Accident_____ Other_____ Date of Accident _____

Employer _____ Employer's Address_____

Occupation_____ Full-time_____ Part-time_____

Are you currently working? _____If no, last day worked_____

Please list your CURRENT medication_____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Please list ALL allergies_____

_____

Please list surgical history_____

_____

Please list Hospitilizations_____

Please list any significant medical changes since you were seen last. _____

_____

Please circle your answers

Drink Caffeine Yes No

Use Tobacco Yes No

Drink alcohol Yes No

Use drugs Yes No

Patient signature_____ Date_____

GREATER PITTSBURGH ORTHOPAEDIC ASSOCIATES

Patient's Full Name_____**Birthdate**_____-____-_____ **Age**_____

Sex: M____ F____Social Security #_____-_____-_____

MAIN # (_____) _____-_____ ALTERNATE # (_____) _____-_____ Work # (_____) _____-_____

Address_____ City_____State_____Zip_____

Email Address_____ Marital Status: S____ M____ D____ W____

Emergency Contact _____Relationship_____Phone (_____) _____-_____

Pharmacy Name/Location **(TOWN)**_____Phone(____)_____-_____

Primary Care Physician _____Phone (_____) _____-_____

Referring Physician Name_____Phone (_____) _____-_____

Parent or legal guardian (If patient is under age 18)*please print*

Parent/Legal guardian's Name_____ Birthdate _____-_____-_____

Address_____ City_____ State_____ Zip_____

Email Address_____ Social Security #_____-_____-_____

Parent or legal guardian's signature_____ Date_____

(Federal Regulations Requirement)*This is a 3 part question*

1) **Ethnicity**: Hispanic /Latino_____ Not Hispanic /Latino_____ Decline_____
2) **Race:** Asian_____ White_____ Black_____ Other_____or Decline_____
3) **Preferred Language:** English_____ Spanish_____ Other_____

With my signature, I confirm the information provided on this page is complete and accurate.

******Signature**_____Date_____

HIPAA

Acknowledgement of receipt of Greater Pittsburgh Orthopaedic Associates Notice of Privacy Practices:

******Signature**_____Date_____

GREATER PITTSBURGH ORTHOPAEDIC ASSOCIATES

Patient's Full Name_____ **Birthdate**_____-____-_____ **Age**_____

Primary Insurance (Please present card for verification)
Insurance Name_____ Specialist Co-payment$_____

Insurance ID #_____ Group #_____ Effective date_____-_____-_____

Address_____ City_____ State_____ Zip_____

Subscriber Name_____ Sex: ___M ___F Birthdate_____-_____-_____

Social Security #_____ Subscriber Address_____

Phone (_____) _____-_____ Cell (_____) _____-_____ Work (_____) _____-_____

Relationship to patient_____

Secondary Insurance (Please present card for verification)
Insurance Name_____ Specialist Co-payment$_____

Insurance ID #_____ Group #_____ Effective date_____-_____-_____

Address_____ City_____ State_____ Zip_____

Subscriber Name_____ Sex: ___M ___F Birthdate_____-_____-_____

Social Security #_____ Subscriber Address_____

Phone (_____) _____-_____ Cell (_____) _____-_____ Work (_____) _____-_____

Relationship to patient_____

Auto/Workers Compensation Claims Injury Description _____

Accident Date/ Injury Date _____ Type of Claim _____Auto _____WC

Auto/Workers Comp Claim #_____

Insurance Name_____ Phone #_____

Address_____ City_____ State_____ Zip_____

Contact Person_____

If workers Comp, Employers name_____ Phone #_____

Billing and Payment

I authorize that payment on my behalf be made directly to Greater Pittsburgh Orthopaedic Associates for all covered charges and any service NOT paid by me. I agree to pay Greater Pittsburgh Orthopaedic Associates for all charges that are not covered or are denied by the insurance carrier. We request that you make payment or payment arrangements within 30 days.

I authorize Greater Pittsburgh Orthopaedic Associates and its agents to release routine information pertaining to my evaluation and treatment to their agents, workers compensation insurance carriers (my employer) referral source, primary care physician, a consulting physician or medical facility, spouse, immediate family members or guardian, or myself to aid in my medical management

******Signature**_____ Date_____

The above-signed authorizations are to be considered valid as long as I am under the care of Greater Pittsburgh Orthopedic Associates unless revoked by written request.3-15