Centennial Orthopedics
Centennial Podiatry
A Division of Mercy Medical Center

Patient's Name ______________________________ ☐ Male ☐ Female
Last First Middle Int.

Mailing Address ______________________________
Box/Street City State Zip

Street Address ______________________________
Street City State Zip

Date of Birth ______________ SS# ______________ Marital Status S / M / D / W / Other

Email Address: ______________________________

Race: ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Hawaiian or Other Pacific Islander ☐ Chinese ☐ Filipino ☐ Japanese ☐ Multi Racial

Language: ☐ English ☐ Spanish ☐ Other ______________________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Home Phone ______________ Cell ______________ May we contact you at work? ☐ Yes ☐ No

May we leave a message? ☐ Yes ☐ No If so, what Phone Number? ______________

Primary Care Provider ______________________________

Emergency Contact ______________________________ Phone ______________

RESPONSIBLE PARTY for the patient

Please circle one: Self / Spouse / Parent / Stepparent / Legal Guardian / Power of Attorney / In-law ________

Name ______________________ Date of Birth __________ Phone ______________

Mailing Address ______________________________
Box/Street City State Zip

Employer ______________________ Work Phone ______________ Ext ________

Additional Guardian Information ______________________ Cell Phone ______________

PRIMARY INSURANCE for the patient

Please circle one: Self / Spouse / Parent / Stepparent / Legal Guardian / Power of Attorney / In-law ________

Insured / Employee's Name ______________________________
Last First Middle Int.

Insurance Name ______________________ Group Name / Employer ______________________

Group # ______________ Policy ID # ______________ Effective Date ______________

Insured's Date of Birth ______________ Insured's SS# ______________________

SECONDARY INSURANCE for the patient

Please circle one: Self / Spouse / Parent / Stepparent / Legal Guardian / Power of Attorney / In-law________

Insured / Employee's Name ____
Last First Middle Int.

Insurance Name ______________________ Group Name / Employer ______________________

Group #____________________ Policy ID #____________________ Effective Date __________

Insured's Date of Birth ______________________ Insured's SS# ______________________

ADDITIONAL INFORMATION

Please provide a list of all the parties we may speak with or leave a message with regarding the patient's medical care, appointment scheduling, or payment information.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

The undersigned patient or individual acting on the behalf of the patient agrees as follows:

1. Authority is granted to Centennial Medical Group to render needed treatment to the above named patient.
2. I authorize Centennial Medical Group to release needed treatment to the above named patient.
3. I authorize payment of medical benefits to Centennial Medical Group, for services rendered.
4. I understand that I am responsible for all charges incurred through Centennial Medical Group.
5. Authorization Period: From ____________ to ____________ OR Lifetime

I request that payment under the medical insurance program be made to the provider named above on any bills for services furnished me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original. If this becomes necessary to effect Collection of my account the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and court costs.

Signature ______________________________________ Date ____________________

CENTENNIAL ORTHOPEDICS
CENTENNIAL PODIATRY
A Division of Mercy Medical Center

Date: ____________________

Patient Health and History Questionnaire

Patient Name: ____ DOB: ________________

Primary Care Physician: ____

Are you being seen for an injury that occurred as a result of an automobile accident, work related accident or other third party liability ❑ Yes ❑ No If yes, what was the date of the injury? ____________________

Please list any allergies to medications: ____

____

Review of Systems: Please check any of the symptoms you have had in the last month.

Constitution: ❑ Unexpected Weight Loss ❑ Weight Gain ❑ Fever ❑ Chills ❑ Night Sweats ❑ Fatigue

Eyes: ❑ Blurry Vision ❑ Watering ❑ Redness

ENT: ❑ Trouble Swallowing ❑ Nosebleeds ❑ Hearing Loss ❑ Earaches ❑ Sinus Congestion ❑ Mouth Sores

Heart: ❑ Chest Pain ❑ Palpitations ❑ Fainting ❑ Murmur ❑ Pacemaker ❑ Defibrillator ❑ Swelling of Feet/Ankle

Resp: ❑ Shortness of Breath with Walking and/or Lying Flat ❑ Wheezing ❑ Snoring

GI: ❑ Heartburn ❑ Nausea/Vomiting ❑ Constipation ❑ Diarrhea

GU: ❑ Frequent/Painful Urination ❑ Blood in Urine ❑ Incontinence ❑ Unusual Vaginal Bleeding

MSK: ❑ Joint Pain ❑ Joint Weakness or Stiffness ❑ Back or Neck Pain ❑ Difficulty Walking

Skin: ❑ Rash ❑ Varicose Veins ❑ Non-Healing Sores ❑ Changes in Warts or Moles ❑ Itching ❑ Redness ❑ Tattoos

Neuro: ❑ Headache ❑ Seizures ❑ Numbness or Tingling ❑ Tremors ❑ Paralysis

Psych: ❑ Memory Loss ❑ Depression ❑ Insomnia

Heme: ❑ Easy Bleeding or Bruising ❑ Problems with Blood Clots ❑ Prior Transfusion

Endo: ❑ Excessive Thirst or Urination ❑ Heat/Cold Intolerance

Allergy/Immune: ❑ Latex ❑ Iodine ❑ Local Anesthetics ❑ Penicillin ❑ HIV

Past Medical History: Please CHECK if you have any of the following medical problems.

Cancers: ❑ Brain ❑ Breast ❑ Rectal ❑ Leukemia ❑ Lung ❑ Lymphoma ❑ Ovarian ❑ Pancreatic ❑ Skin ❑ Benign Tumor ❑ Cancerous Tumor

Heart Disease: ❑ Congestive Heart Failure ❑ Deep Vein Thrombosis ❑ Hypercholesterolemia ❑ Hypertension ❑ Myocardial Infarction (Heart Attack) ❑ Stroke ❑ Atrial Fibrillation

EENT: ❑ Eye Disease ❑ Glaucoma ❑ Hay Fever ❑ Otitis Media (Ear Infection) ❑ Cataracts

Skin: ❑ Dysplastic Moles

Musculoskeletal: ❑ Arthritis ❑ Chronic Back Pain ❑ Fibromyalgia ❑ Fracture ❑ Osteoarthritis
❑ Osteoporosis ❑ Rheumatoid Arthritis

Endocrine: ❑ Autoimmune Disorder ❑ Diabetes Type 1 ❑ Diabetes Type 2 ❑ Hyperthryoidism
❑ Hypothyroidism

Respiratory: ❑ Asthma ❑ COPD ❑ Pneumonia ❑ Pulmonary Embolism ❑ Sleep Apnea ❑ TB

Neurological: ❑ Chronic Headaches ❑ Epilepsy ❑ Migraines ❑ Neurological Disease
❑ Seizure Disorder

Pysch/Social: ❑ Anxiety Disorder ❑ Bi-Polar ❑ Dementia ❑ Depression ❑ Development Disorder
❑ Psychiatric Illness ❑ Substance Abuse ❑ Suicide Attempt

Gastrointestinal: ❑ Diverticulitis ❑ Diverticulosis ❑ GERD ❑ GI Bleed ❑ Hepatitis
❑ Liver Disease ❑ Ulcer ❑ Ulcerative Colitis

Renal: ❑ Kidney Disease ❑ Kidney Failure ❑ Kidney Stones ❑ Urinary Disorder

Other: ❑ Anemia ❑ Bleeding Disorders ❑ Blood Transfusion ❑ Clotting Disorders
❑ Peripheral Vascular Disease

Please list other medical problems not checked above.

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Please list all past surgeries or procedures:

Surgery/Procedure: Year:

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Family History: Does anyone in your family have or is deceased from the following.

Cancer: ____________________

Heart Disease: ____________________

Diabetes/Renal (Kidney): ____________________

Respiratory: ____________________

Psychiatric: ____________________

Blood Clots: ____________________

Other: ____________________

Social History:

Occupation: ____________________

Place of Employment: ____________________

Lives With: ____________________

Marital Status: ____________________

Nickname you would prefer to be called if other than your legal name: ____________________

Risk Factors: Please CHECK and answer the questions below.

Tobacco: ❑ Cigarettes ❑ Cigars ❑ Smokeless (Chew)

How much a day? ____________________ How long? ____________________

If you quit smoking/chew: When did you start? ____________________

When did you quit: ____________________

Alcohol: Do you drink ❑ Yes ❑ No

What kind? ____________________ Average drinks per day? ____________________

Drugs: ❑ Marijuana ❑ Cocaine ❑ Meth ❑ Heroin ❑ None

____

Printed Name

____

Signature Relationship to Patient Date

CMG A DIVISION OF MERCY MEDICAL CENTER

Centennial Medical Group Consent / Authorization

Consent to Treatment: I have a condition requiring examination, diagnosis, and/or treatment and hereby consent to and authorize such customary care including, but not limited to: x-ray, laboratory, routine diagnostic tests and therapeutic procedures ("Services") performed by my admitting and treating health care provider(s) ("Providers") who may or may not be employed by Centennial Medical Group and his or her assistants or designees, including personnel employed by Centennial Medical Group. I understand that photographs, videotapes, digital or other images may be recorded to document my care, and I consent to this and for Centennial Medical Group to retain ownership rights to these images. A separate consent for photography form will be obtained for disclosure of any images outside of Centennial Medical Group that identify me and are used for purposes such as education or marketing. I understand that such care may involve risks and that no guarantees have been made to me concerning the results of this treatment or examination. I further understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures/treatment. For any notice or authorization referenced herein, a copy of this form can be used in place of the original.

Clinical Education and Research: I agree to the supervised participation of health care learners (e.g., medical students, nursing students, interns, residents, fellows, other clinical students, etc.) in my care. I understand that patient records and specimens obtained from my body for medical care purposes may be used in research. Research involving records and specimens will be conducted in such a manner that patients cannot be identified without their written consent. No other treatment, procedure or studies will be performed solely for research purposes without the separate written informed consent of the patient.

Permission to Photograph: I understand that photographs, videotapes, digital or other images may be recorded to document my care, and I consent to this and for Centennial Medical Group to retain ownership rights to these images. A separate "consent for photography" form will be obtained for disclosure of any images outside of Centennial Medical Group that identify me and are used for purposes such as education and marketing.

Electronic Health Records: I understand this office participates in the DCIPA Community Health Record Database. This means Centennial Medical Group will enter my health information, including chart notes, prescription records, operatory notes, radiographs and scans, lab results, and other health information in a secure shared database accessible only to other participating community healthcare providers. My other medical providers participating in the shared database do the same thing, permitting all participating providers ready access to up to date information regarding my condition and care. Participating in this shared database allows my healthcare providers to provide me better care with less hassle. By signing below, I agree Centennial Medical Group may upload my health information onto the database, view all of my personal health information on the database, and share my personal health information with other participating providers through the database. I understand that, with certain expectations, if I refuse to permit my health information to be included in this shared database, Centennial Medical Group may refuse to treat me.

Independent Status of Providers: I recognize that not all health care providers who provide Services to me during this admission are employees or agents of Centennial Medical Group. Such individuals are INDEPENDENT CONTRACTORS who are granted privileges to use Centennial Medical Group for private Patients and bill separately for their services. In addition, I understand that Centennial Medical Group is not responsible for nor does it assume any liability for the acts or omissions of any such independent contractors.

Assignment of Facility and Professional Benefits: I hereby assign all insurance benefits and/or Medicare/Medicaid benefits to Centennial Medical Group or Providers and authorize direct payment to Centennial Medical Group or Provider, as the case may be. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. This assignment also includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

Authorized Representative: I hereby authorize Centennial Medical Group, its agents or representatives to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for Services provided to me.

Financial Responsibility: I understand that I am financially responsible to Centennial Medical Group as the patient, parent, guardian, conservator or insured for all charges not covered by the above assignments. Charges may include medical insurance deductibles, co-insurance, out-of-pocket expenses, or the extra cost of a private room in which l am placed at my own request. l authorize the Centennial Medical Group or Provider(s) to access and review my credit report for purposes related to billing or collection of accounts.

Pharmacy Health Information Exchange: I consent to Centennial Medical Group obtaining my medication history information electronically through a pharmacy health information exchange for appropriate care and to avoid adverse drug reactions.

Communication Consent: By providing my cell, landline, or any other numbers(s), I expressly consent to receiving communications from Centennial Medical Group, its staff, its contractors, collection agents, and others, at any number I provide. Centennial Medical Group may use this information to contact me by live agent, voice mail, text message, using an auto-dialer or other computer assisted technology, per-recorded message(s), or by any other form of electronic communication for any purpose, including but not limited to, appointment and follow-up health care reminders, scheduling, my account(s), assignment of benefits, and/or financial responsibility. I understand that, depending on my phone plan, I could be charged for these calls or text messages. I agree to provide new number(s) if my number(s) change. Providing these numbers is not a condition of receiving services.

Personal Equipment and Valuables: I understand that Centennial Medical Group maintains a safe for the safekeeping of money and valuables. I understand that Centennial Medical Group shall not be liable for the loss or damage of my personal property. I accept full responsibility for all property kept in my possession. I also understand that I must inform the admissions clerk or a nurse if I bring any electrical equipment to Centennial Medical Group (e.g. ventilators; BIPAP machine, CPAP machine) and adhere to Centennial Medical Group policies regarding its use. I assume full responsibility for such electrical equipment and for any injury caused by the use of the electrical equipment brought from home.

Acknowledgment of receipt of notice of privacy practices, patient rights and responsibilities information.

Please initial: _____________ I acknowledge that I was provided with a copy of the Notice of Privacy Practices and information about my patient rights and responsibilities.

The undersigned certifies that he or she has read the foregoing, is the patient, patient's guardian, power of attorney, parent or is duly authorized by or on behalf of the parent to execute the above and accept its terms

______________________________ Patient's Signature/Parent if Minor/Power of Attorney/Guardian

______________________________ Relationship

______________________________ Date/Time

______________________________ Responsible Party's Signature (If Not Same as Patient or Parent)

______________________________ Responsible Party's Signature

______________________________ Witness to Signature

______________________________ Patient Unable to Sign Consent Because

______________________________ Name and/or ID of Interpreter, if used/applicable

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PAYMENT and INSURANCE POLICY

Welcome to our practice. We hope the following will answer any questions you have regarding our payment and insurance policy. If you have any questions please feel free to call our office.

Uninsured/Charity: If you have no insurance a $100 deposit is required at the time of service regardless of any financial assistance granted through the Centennial Medical Group Charity Policy. If you have any questions, please contact our office for an application.

Co-pays: The patient is responsible for any Co-pay for visits. Co-pays will be collect at the time of check in. For convenience we accept cash, check, Visa, MasterCard and Discover.

Insurance/Deductible Balance: The patient is responsible for any insurance deductible of balance and it will be collected at the time of check in for your appointment. For convenience we accept cash, check, Visa, MasterCard and Discover.

Insurance: As a courtesy, our office will bill the primary insurance company. It is the patient's responsibility to provide us with accurate, current insurance information. Please bring current insurance cards to the appointment.

If the patient has secondary insurance coverage and provides us with the current valid information, we will bill secondary insurance after we have received response from primary insurance.

Coverage and Benefits: Please be aware, it is the patient's responsibility to verify optimal coverage, benefits and limitations with their insurance company. Please call your insurance company if you have any questions regarding your coverage.

____ ____________________

Signature of Acceptance Date