ORTHOPAEDIC CENTER OF THE VIRGINIAS

311 Courthouse Road
Princeton, WV 24740
(304) 487-2297

Name: _____ SSN: _____
DOB: _____ Date: _____

1/

Patient Health History Form

Chief Complaint

Why are you seeing the doctor today?

DOI: Surgery Date:

Medication	Dose

Medication	Dose

Allergy	Reaction

Allergy	Reaction

Employment Status: Full Time Part Time Retired Disabled Unemployed

Occupation: _____

Marital Status: _____ Children: _____ Handed: Left or Right

Exercise: _____ Type: _____

Tobacco: _____ Use: _____ Quit: _____

Alcohol: _____ How Often: _____

Past Surgical History

Surgeries/Hospitalizations	Year	Complications

☐ See Past Medical Appendix

Have you ever had general anesthesia? ☐ Yes

Have any problems with anesthesia? ☐ Yes Describe:

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Name: _____ SSN: _____
DOB: _____ Date: _____

Past Medical History

- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Diabetes
- ☐ Cholesterol
- ☐ Pulmonary
- ☐ Arthritis
- ☐ Cancer
- ☐ Stroke
- ☐ Prostate
- ☐ Female
- ☐ Bleeding
- ☐ Thyroid
- ☐ Osteoporosis
- ☐ Ulcers
- ☐ Blood Clots
- ☐ HIV
- ☐ Hepatitis
- ☐ Other
- ☐ Other

Family History

Circle

Mother Alive Age:____ Deceased Age:____ Unkown Cause of Death_____

Father Alive Age:____ Deceased Age:____ Unkown Cause of Death_____

How many Brothers? _____ How many Sisters? _____

☐ High Blood Pressure	Mother	Father	Sister	Brother	Grandfather	Grandmother	Aunt	Uncle
☐ Heart Attack	Mother	Father	Sister	Brother	Grandfather	Grandmother	Aunt	Uncle
☐ Diabetes	Mother	Father	Sister	Brother	Grandfather	Grandmother	Aunt	Uncle
☐ Cholesterol	Mother	Father	Sister	Brother	Grandfather	Grandmother	Aunt	Uncle
☐ Cancer	Mother	Father	Sister	Brother	Grandfather	Grandmother	Aunt	Uncle
☐ Stroke	Mother	Father	Sister	Brother	Grandfather	Grandmother	Aunt	Uncle
☐ Bleeding	Mother	Father	Sister	Brother	Grandfather	Grandmother	Aunt	Uncle
☐ Blood Clots	Mother	Father	Sister	Brother	Grandfather	Grandmother	Aunt	Uncle
☐ Neurological Condition	Mother	Father	Sister	Brother	Grandfather	Grandmother	Aunt	Uncle
☐ Other	Mother	Father	Sister	Brother	Grandfather	Grandmother	Aunt	Uncle
☐ Other	Mother	Father	Sister	Brother	Grandfather	Grandmother	Aunt	Uncle

Patient Signature: _____ Date_____

PATIENT REGISTRATION INFORMATION

Name: _____ SSN: _____

Date of Birth: _____ Email: _____

PHARMACY: _____ **CITY/STATE** _____

If patient is under 18, please fill out following information for responsible party:

Name: _____ Date of Birth: _____ Home Phone: _____

Address: _____

City/State/Zip: _____ Employer: _____

SSN: _____ Relationship: _____ Occupation: _____

If Insured party is different from responsible party, Please fill out the following information:

Name: _____ Date of Birth: _____ Home Phone: _____

Address: _____

City/State/Zip: _____ Employer: _____

SSN: _____ Relationship: _____ Occupation: _____

What body part are you being seen for today? (Please specify left or right side)

_____

Is your visit today related to an injury? _____ Yes Date of Injury: _____

_____ No

If this is related to an injury, please give a brief summary of what happened?
If this is not related to an injury, please describe your symptoms and how long they have been occurring:

_____

_____

_____

_____

LEGAL REPRESENTATION/OTHER RESPONSIBLE PARTIES: Yes ____ No ____ Name and Address _____

Patient/Guarantor Please Read And Sign:

I request payment of health benefits to my attending physician whether it be Darrell C Belcher, M.D., Philip Branson, M. D., Robert Kropac, M.D. , Frederick Morgan, D.O., for services rendered to me. I do however understand that I am responsible for all charges incurred. I authorize the Orthopaedic Center of the Virginias to release any information, verbal or written, to all parties involved regarding my medical condition. This is to include any medical records, reports, x-rays, or other related information. In the event that an overpayment would occur for Darrell C Belcher, M.D.; Philip Branson, M. D.; Robert Kropac, M.D.; Frederick Morgan, D.O.. hereby authorize The Orthopaedic Center of the Virginias to apply the overpayment to any outstanding accounts that I have in this office.

→**Patient/Guarantor Signature** X_____Date: _____

Darrell Belcher, Philip Branson, Robert Kropac, & Frederick Morgan
PATIENT INFORMATION & DESIGNATED INDIVIDUALS CONSENT FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

I have been informed that the Notice of Patient Information Practices is posted in the lobby and in the examination rooms of Darrell Belcher, Philip Branson, Robert Kropac, and Frederick Morgan. I have been offered a copy from Darrell Belcher, Philip Branson, Robert Kropac, and Frederick Morgan's Notice of Information Practices. I understand that my treating physician may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that my physician will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Darrell Belcher, Philip Branson, Robert Kropac, or Frederick Morgan Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date