CHESTERTOWN ORTHOPEDICS & SPORTS MEDICINE

Frederick T. Lohr, M.D., P.A. | Paul D. Simonetti, PT, DPT, MTC | David G. Collier, PT,MPT

Personal Information: (Please fill out ALL of these forms completely to the best of your knowledge.)

Family Doctor: Dr. Meixner Referred by: Dr. Borling

Last Name: Brown First Name: Jordan Middle Initial: A.

Mailing Address: 123 Main St., Chicago, IL 60608

911 Address: Same

City: Chicago State: IL Zip: 60608 County: Cook

Home Phone: 312-123-4567 Cell Phone: Same SSN#: 123-45-6789

DOB: 03/05/2007 Age: 4 Gender: (M) F Marital Status: M (S)

Employer: None Work Phone: N/A

Student: ☐ Part-time ☐ Full-time School: — Type of Ins. (Circle): Auto WC (Health) Self Pay

♦ College Students - Local address and phone #:

Emergency Contact: Mom Phone#:

Medical History: Last visit = Jordan = 3 y.o.; Gowers sign noted + weakness in arms, pelvis, legs

Reason of visit: (Left) (Right) Extreme muscular pain in legs; shortness of breath; sits hunched over

♦Date of Injury: ~1 month ago (Where, When & How): Patient can't remember; constant pain

X-rays: Y N Date: ___/___/___ ER? Y (N) Date: ___/___/___ MRI Scan: Y (N) Date: ___/___/___

In which hospital ER were you seen? None; 35 lbs; 2'2"

Medications presently taking: Y N Please List Current Medications: Calcium & Fluoride Supplements

Drug Allergies: Y (N) Please List Drugs:

1. Co-Pays are due at the time of Services. I understand and agree that (regardless of my insurance status) that I am ultimately responsible for the balance of my account for any professional services rendered. I authorize the release of any medical information necessary to process my claim. I have furnished the above information and certify that it is true and correct to the best of my knowledge. I will notify Chestertown Orthopedics of any change in my health status and/or information above. As a courtesy, we can supply you with a computerized bill for your records upon request. There is a fee for completion of any individual insurance forms that must be processed by our office. **I AGREE TO PAY FOR SERVICES AND/OR SUPPLIES RECEIVED IF SUCH SERVICES AND/OR SUPPLIES ARE DENIED BY MY INSURANCE COMPANY/CARRIER.**

2. Release of Information: All records concerning the patient's treatment remain the property of Chestertown Orthopedics, although the patient may obtain a copy by making a written request. As a condition of the patient receiving medical care at Chestertown Orthopedics, the undersigned consents to the use and disclosure of health information about the patient, including any other health care providers (i) in order to carry out that care and treatment of the patient, (ii) to the extent necessary to determine liability for payment and to obtain reimbursement, and (iii) for Chestertown Orthopedic internal health care operation, such as quality improvement, risk management, credentialing, peer review, business management, etc.

3. Medicare or Medicaid Benefits: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I request the payment of authorized Medicare benefits. I authorize a holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I understand that Medicare will pay only for services which they determine to be reasonable and necessary under Section1862(a)(1) of the Medicare Law. If Medicare denies payment for some or all of these services, I agree to pay for them.

The undersigned certifies that he/she has read and understands the foregoing, and is the patient or is duly authorized to act on behalf of the patient.

Acknowledgment of Privacy Practices

I acknowledge receipt of Chestertown Orthopedics Notice of Privacy Practices for Protected Health Information

Signature: M Brown Date: 10/11/11

Printed Name: M. Brown Witness: AA