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 _____ Responsible Party's 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 Name Relationship

_____ _____
Name Relationship Name Relationship

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 _____

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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 _____

2460 NW Stewart Parkway, Suite 100 • Roseburg, OR 97471 • Phone: 541-229-2663 • Fax: 541-229-0213

CENTENNIAL ORTHOPEDICS
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ACCIDENT/INJURY/INFORMATION FORM

Please answer all questions and sign the bottom of the form.

If the reason for your appointment is not related to an accident or injury please skip to #4

Date of Injury: _____ **Time:** _____

Location: _____

Briefly describe how the injury occurred: _____

_____

_____

_____

_____

1. **Is this an On the Job Injury?** ☐ Yes ☐ No (If no proceed to #2)
   If yes,Claim number: _____
   Employer at time of injury: _____
   Work Comp. Carrier: _____ Phone: _____
   Date of Injury: _____ Status of Claim: ☐ Open ☐ Closed ☐ Deferred
   Denied Date: _____

2. **Is this a Motor Vehicle Injury?** ☐ Yes ☐ No (If no proceed to #3)
   If yes,Claim number: _____
   Auto Insurance Carrier: _____
   Agent Name: _____ Phone: _____
   Date of Injury: _____ Status of Claim: ☐ Open ☐ Closed ☐ Deferred
   Denied Date: _____

3. **Do you have an attorney in regards to this injury?** ☐ Yes ☐ No (If no proceed to #4)
   Attomey Name: _____ Phone: _____

4. **What insurance are you requesting we bill for this visit:**

   _____

5. ☐ **Please initial this box and sign below to certify the treatment you are requesting today is not related to a Motor Vehicle Accident, Work related accident or Third Party Liability.**

By signing below, I certify that the information is true and complete to the best of my knowledge.

Patient Name: _____

Patient Signature: _____ Date: _____

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CENTENNIAL ORTHOPEDICS
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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.

Please list all past surgeries or procedures:

Surgery/Procedure: Year:

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

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Centennial Orthopedics/Centennial Podiatry Consent / Authorization

Patient Full Name: _____ Patient Date of Birth: _____

I agree my health information may be used to assist with my treatment, seek payment for health care services and products, and in routine practice operations, and I have received this office's Notice of Privacy Practices. _____

I agree **Centennial Medical Group/Centennial Orthopedics/Centennial Podiatry** may furnish my insurance companies with all information they request concerning my treatment, including all of my personal health information. _____

I understand there may be contact with a behavioral/mental health consultant and from time to time other persons may be observing or facilitating my care. Such persons may include but not limited to; students of the health profession, administrative or health care professionals in orientation or training. _____

I assign to **Centennial Medical Group/Centennial Orthopedics/Centennial Podiatry** all payments I become entitled to receive for services and products provided to me by **Centennial Medical Group/Centennial Orthopedics/Centennial Podiatry.** _____

I understand I must pay all co-payments, deductibles, and other charges not covered by insurance companies or other benefit programs. I understand that if these benefits stop for any reason, I must pay for all services and products provided. _____

I agree to pay for services and products provided if for any reason insurance companies and other benefits plans do not pay. If I do not provide complete and correct insurance information, I may have to pay charges that would otherwise be covered by insurance. If my insurance requires a referral, and I do not have the necessary referral I will be responsible for paying for all services and products provided. If I file a Workers' Compensation claim, I authorize **Centennial Medical Group/Centennial Orthopedics/Centennial Podiatry** to release my personal health information, including information about my condition and treatments, to the Workers' Compensation insurance company, my employer, and my lawyer. I understand I may request a copy of my own health information, propose changes or additions, and receive a list of non-treatment related disclosures of the information. _____

I understand this office participates in the DCIPA Community Health Record Database. This means **Centennial Medical Group/Centennial Orthopedics/Centennial Podiatry** 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/Centennial Orthopedics/Centennial Podiatry** 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/Centennial Orthopedics/Centennial Podiatry** may refuse to treat me. _____

I authorize **Centennial Medical Group/Centennial Orthopedics/Centennial Podiatry** to render medical products and services, including diagnosis and treatment, laboratory testing, x-rays and scans, and other medical services as deemed necessary by my physician. _____

I agree **Centennial Medical Group/Centennial Orthopedics/Centennial Podiatry** may from time to time take photographs of me and keep them with my medical records. I agree that all my medical providers may use these photographs for identification purposes, to prevent fraud, and to assist with my medical care. _____

Patient Signature: _____ Date: _____

Other Signature or Legal Guardian: _____