MULLEN
ORTHOPEDIC CLINIC

Patient Name: _____ **DOB:** _____ **Age:** _____ **Date:** _____

Reason for Visit (include Body Part & Rt/Lt): _____

Height: _____ **Weight:** _____ **Primary Care Dr:** _____

Onset date of injury/illness: _____

Due to: Auto Accident? ☐ **Yes** ☐ **No** **Work Related?** ☐ **Yes** ☐ **No**

MEDICATIONS: ☐ **NONE**

NAME OF MEDICATION	REASON FOR MEDICATION

ALLERGIES: ☐ **NONE**

MEDICATION	REACTION

MULLEN
ORTHOPEDIC CLINIC

Patient Name: _____ **DOB:** _____

SURGICAL HISTORY: LIST EVERY SURGERY YOU HAVE EVER HAD ☐ **NONE**

YEAR	PROCEDURE

FAMILY HISTORY: ☐**Unknown**

INHERITABLE DISEASES	FAMILY MEMBER

SOCIAL HISTORY:

Do you now or have you ever smoked? ☐ NO ☐ YES If yes, how often?_____ How many?_____ Year quit?_____

Do you consume alcohol? ☐ NO ☐ YES Daily? ☐ NO ☐ YES If daily, for how long?_____

Employed ☐ **Occupation** _____

Retired ☐ **Former Occupation** _____

Student ☐ **Name of School** _____

☐ **Right-Handed** ☐ **Left-Handed** ☐ **Ambidextrous**

REVIEW OF SYSTEMS: **PLEASE MARK ALL THAT APPLY**

- Constitutional-
☐ Change of Appetite
☐ Fever

-Ophthalmologic-
☐ Blurred vision
☐ Discharge

-ENT-
☐ Decreased hearing
☐ Sore throat

-Endocrine-
☐ Cold intolerance
☐ Excessive Thirst

-Respiratory-
☐ Cough
☐ Wheezing

-Cardiovascular-
☐ Irregular heartbeat
☐ Palpitations

-Gastrointestinal-
☐ Constipation
☐ Diarrhea

-Genitourinary-
☐ Blood in urine
☐ Difficulty urinating

-Musculoskeletal-
☐ Painful joints
☐ Weakness

-Skin-
☐ Itching
☐ Rash

-Neurologic-
☐ Fainting
☐ Headache

-Psychiatric-
☐ Anxiety
☐ Depressed Mood

MULLEN
ORTHOPEDIC CLINIC

Patient's Name (Last, First, MI) _____

Local Address _____

City _____ State _____ Zip _____

Permanent Address (if different) _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

Primary Care Physician _____ PCP Phone #: _____

Date of Birth ____ / ____ / _____ Sex ☐ M ☐ F Marital Status ☐ S ☐ M ☐ D ☐ W

Social Security#_____ Employer _____ Phone_____

Emergency Contact _____ Relation _____ Phone _____

Responsible Party (if patient is a minor) _____ Phone_____

Preferred contact: ☐ **Home Phone** ☐ **Cell Phone** ☐ **Work Phone** **OK to leave message?** ☐ **Yes** ☐ **No**

Preferred reminder method: ☐ **Voice Mail** ☐ **Text** ☐ **Email**

Pharmacy _____ Cross streets _____ Phone _____

*Primary Language*_____ *New Federal Standards for Electronic Health Records ask for the following info:*

☐ *American Indian* ☐ *Asian* ☐ *Hawaiian/Pac Islander* ☐*African American* ☐*White* ☐ *Hispanic* ☐*Other*

INSURANCE INFORMATION MUST BE COMPLETED HERE ALSO

Primary Insurance Company _____

Policy Holder _____ Date of Birth _____ / _____ / _____

ID/Policy # _____ Group # _____ Co-Pay_____

Secondary Insurance Company _____

Policy Holder _____ Date of Birth _____ / _____ / _____

ID/Policy # _____ Group # _____ Co-Pay_____

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to the provider for services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and my signature below will bind me as though I personally signed the claim. I **understand that I am responsible for all charges not covered by my insurance**. I authorize the release of any medical or other information necessary to process my medical claims. I have read and understand the office policy and procedures. (Copy attached)

_____ _____

Signature of the Patient or the Patient's Legal Representative Date

_____ _____

Print Name Relationship to Patient

MULLEN
ORTHOPEDIC CLINIC

Patient Communication and Consent

Patient Name: _____ DOB: _____

There are occasions when Mullen Orthopedic Clinic, PLC may have to call to discuss Confidential Protected Health Information. Please let us know how you would like to receive this information.

_____ Ok to call my home/cell phone and leave messages on the answering machine

_____ Ok to call my home but DO NOT leave a message

ALL 4 PAGES MUST BE COMPLETED PRIOR TO SEEING DR

Who may receive information regarding your Confidential Protected Health Information?

NAME	DATE OF BIRTH	RELATIONSHIP	PHONE #

I acknowledge reading the laminated Notice of Privacy Practices copy provided from this provider and authorize the above list of persons who may receive my Protected Health Information. I may revoke authorization by giving written notification to Mullen Orthopedic Clinic PLC, except to the extent that the information has been relayed PRIOR to my revocation.

PLEASE NOTIFY US IF YOU WISH TO RECEIVE A PAPER COPY OF PRIVACY PRACTICES

Signature: _____ Date: _____

Patient Online Portal

We are pleased to announce the introduction of an online patient service through our website for the exclusive use of established patients. Patient Portal lets patients communicate with their doctor and access important information over the Internet.
The Patient Portal is a voluntary option and is free of charge to all patients.

Once you have signed this Portal Authorization Consent and have provided Mullen Orthopedic Clinic, PLC with a valid email address, you will be emailed a system generated unique user identification and password.
You may change your password after initial log in to the Patient Portal.

Patient Acknowledgment and Agreement for access to Patient Portal

_____ _____

Signature of Patient or Legal Guardian Date

Email (please print):