

KENTUCKY BONE & JOINT SURGEONS

A Division of Ortho Kentucky, PLLC

230 Fountain Court, Suite 180
Lexington, KY 40509

107 Meridian Way, Suite 200
Richmond, KY 40475

Phone: (859) 276-5008

Fax: (859) 278-6401

Welcome to our practice. Enclosed you will find some new patient information forms you will need to fill out and bring with you to your appointment. Other items to bring with you include a picture form of ID (this is required for all patients), your current insurance card, and all x-rays, MRI's, CT scans, and notes pertaining to your injury we are seeing you for.

We will file your insurance for you but want you to understand that the final responsibility for your charges is yours. Copayments and deductibles are due at the time of service. We gladly accept cash, check, Visa, MasterCard and Discover.

It is the responsibility of the patient to check with his/her insurance company to make sure we are a participating provider and that he/she is covered for the visit scheduled. With the increasing number of insurance companies and plan types there is no way for us to know all participating insurance types.

If your insurance requires a referral from your primary care doctor, it is your responsibility to contact your primary care doctor office and make sure they get the referral to us prior to your appointment date. The insurance companies will not allow us to obtain these referrals. It is also your responsibility to make sure the visits are current and not expired. If it happens that you are seen and the insurance denies payment for lack of referral, the payment responsibility is yours.

There are certain services such as cast boots, fracture walkers, ace bandages, heel pads, etc, that are not covered by Medicare and many other insurance carriers. If these services are not covered you will be billed for them.

We appreciate your cooperation and apologize for any inconvenience to you but the continued demands and different coverage's now offered by many insurance companies require us to explain our position. By signing below you acknowledge you have read and agree to the conditions above. Thank you.

Signature/Date

Name: _____ Age: _____ DOB: _____ Sex: _____

Home address: _____ City/State: _____ Zip: _____

Social Security # _____ Marital Status: _____ Spouse Name _____

Referred to us by whom: _____ Home Phone: _____

Your place of employment: _____ Position: _____ Phone: _____

Spouse's employment: _____ Position: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

If patient is under 18, please complete:

Mother's Name: _____ Father's Name: _____

Employer: _____ Employer: _____

Position: _____ Phone: _____ Position: _____ Phone: _____

Insurance Information: Please bring card with you to appointment so we may make a copy.

IF THIS IS WORKER'S COMPENSATION OR ACCIDENT (AUTO OR PERSONAL) FILL OUT

INFORMATION BELOW:

Claim Number: _____ Carrier: _____

Contact person/phone/address/fax numbers: _____

Billing address: _____ City/State/Zip: _____

MEDICAL INFORMATION:

Chief Complaint: _____

Is this due to an injury, please explain: _____

Are you allergic to Latex: YES NO Drug allergies: YES NO Please list below:

I give my permission for Kentucky Bone & Joint surgeons to release my medical records to my insurance company, other physicians, or attorney.

Signed/Date: _____

Permission is hereby granted to release my medical records and/or x-rays to Kentucky Bone & Joint Surgeons.

Signed/Date: _____

Name: _____ Date: _____

Please circle yes or no for each of the following concerning your health history. If you answer yes to any, please use the space at the bottom of the page to explain.

GENERAL

Serious illness recently	YES	NO
Fever	YES	NO
Weight Change	YES	NO

EYES

Glaucoma	YES	NO
Decreased Vision	YES	NO

EAR, NOSE, THROAT

Decreased vision	YES	NO
Bleeding from nose	YES	NO
Trouble swallowing	YES	NO

CARDIOVASCULAR

High blood pressure	YES	NO
Chest pain	YES	NO
History of heart attack	YES	NO
Shortness of breath after exercise	YES	NO
History of heart failure	YES	NO
Irregular heart beat	YES	NO
Elevated cholesterol	YES	NO

LUNGS

Asthma	YES	NO
Bronchitis	YES	NO
Chronic Cough	YES	NO
Cough up blood	YES	NO
Shortness of breath	YES	NO
History of Tuberculosis	YES	NO

GASTROINTESTINAL

History of ulcer	YES	NO
History of colitis	YES	NO
Gallstones	YES	NO
Stomach pain	YES	NO
Change in bowel habits	YES	NO

KIDNEYS

Difficulty voiding	YES	NO
Blood in urine	YES	NO
Infection	YES	NO

MUSCULOSKELETAL

Joint Pain	YES	NO
Swollen Joint	YES	NO
Broken bone	YES	NO
Muscle pain	YES	NO
Arthritis	YES	NO

SKIN/BREAST

Non-healing sore	YES	NO
Eczema	YES	NO
Breast lump	YES	NO

NEUROLOGIC

History of stroke	YES	NO
Seizure	YES	NO
Headaches	YES	NO
Dizziness	YES	NO

PSYCHIATRIC

Depression	YES	NO
Psychiatric treatment	YES	NO

ENDOCRINE

Diabetes	YES	NO
Thyroid Problems	YES	NO

BLOOD

Bleed easily	YES	NO
Swollen glands	YES	NO
Bruise easily	YES	NO