



SEPEHR BADY, MD
THOMMAN KURUVILLA, DPM
X. NICK LIU, DO
TIMOTHY J. TRAINOR, MD
RANDALL E. YEE, D

PATIENT INFORMATION

ODAYS DATE: WHICH DOCTOR ARE YOU SEEING? BADY KURUVILLA LIU TRAINOR YEE
PATIENT: LAST NAME FIRST MIDDLE
ADDRESS CITY STATE ZIP
HOME PHONE: WORK PH: CELL PH
SSN SEX: MALE FEMALE DATE OF BIRTH: AGE
MARITAL STATUS: MARRIED SINGLE DIVORCED SEPARATED WIDOWED
IF PATIENT IS A MINOR: PARENT/GUARDIAN LAST NAME FIRST NAME
PATIENTS EMPLOYER OCCUPATION
EMPLOYER ADDRESS CITY STATE ZIP

GUARANTOR INFORMATION

PERSON RESPONSIBLE FOR BILL: LAST NAME FIRST
GUARANTOR ADDRESS CITY STATE ZIP
HOME PHONE: WORK PH: CELL PH
SSN SEX: MALE FEMALE DATE OF BIRTH: AGE

EMERGENCY CONTACTS

NAME OF LOCAL FRIEND OR RELATIVE:
LAST NAME: FIRST RELATIONSHIP TO PATIENT
HOME PHONE: WORK PH: CELL PH

INSURANCE INFORMATION

PRIMARY INSURANCE CO NAME PHONE
ADDRESS TO MAIL CLAIMS: CITY STATE ZIP
POLICY HOLDER: LAST NAME FIRST NAME INITIAL
SSN DATE OF BIRTH RELATION TO PATIENT:
POLICY/ID# GROUP # EMPLOYER CITY STATE
SECOND INSURANCE CO NAME PHONE
ADDRESS TO MAIL CLAIMS: CITY STATE ZIP
POLICY HOLDER: LAST NAME FIRST NAME INITIAL
SSN DATE OF BIRTH RELATION TO PATIENT:
POLICY/ID# GROUP # EMPLOYER CITY STATE

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Advanced Orthopedics, Sepehr Bady, M.D., Thomman Kuruvilla, DPM, X Nick Liu, D.O., Timothy J. Trainor, M. D. or Randall E. Yee, D.O. or insurance company to release any information required to process my claims.

X
PATIENT OR GUARDIAN SIGNATURE DATE

**ADVANCED ORTHOPEDICS & SPORTS MEDICINE**

**STATEMENT OF PERSONAL INJURY – POSSIBLE THIRD PARTY LIABILITY**

**THIS FORM MUST BE FILLED OUT**

Please fill out this form to give your insurance company the information they need to process your claim without delay. Your claims will be suspended by your insurance company until they receive information on the details behind your injury.

**SECTION 1 – GENERAL INFORMATION**

- 1. Injured Patients Name: \_\_\_\_\_
- 2. How did the injury occur: \_\_\_\_\_
- 3. Date Injury Occurred: \_\_\_\_\_ State Where Injury Occurred: \_\_\_\_\_

\*IF AUTO ACCIDENT, WERE YOU: (CIRCLE ONE) DRIVER PASSENGER FRONT PASSENGER REAR MOTORCYCLE DRIVER  
MOTORCYCLE PASSENGER  
WERE YOU WEARING A SEATBELT AT THE TIME OF ACCIDENT?  YES

**SECTION 2 – TYPE AND CAUSE OF INJURY**

- 5. ( ) Traffic Accident – (Give name of your car insurance and policy information or at-fault driver and their insurance policy information. If Car Accident, we need to bill your car insurance before we can bill your private insurance or your private insurance might not pay your claim.)
  
- 6. ( ) Slip/Fall, Dog Bite, Mishap Injury (Give details of injury, business, or homeowner where injury occurred.)
  
- 7. ( ) On the job injury (Give name and address of employer, cause of injury, and work compensation insurance policy. We need to bill your work comp carrier.)

**WE MUST HAVE COMPLETE AND ACCURATE INFORMATION IN ALL SECTIONS!**

(PLEASE ASK FOR ASSISTANCE WITH PHONE BOOKS, OR PHONE CALLS IF NEEDED FOR ADDRESSES AND PHONE NUMBERS.)

Name of employer AT TIME OF INJURY \_\_\_\_\_ SUPERVISORS NAME: FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_

EMPLOYER (AT TIME OF INJURY)

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMPLOYER (AT TIME OF INJURY: PHONE #: AREA CODE ( \_\_\_\_\_ ) \_\_\_\_\_ DATE OF

INJURY \_\_\_\_\_ /MO \_\_\_\_\_ DAY/ \_\_\_\_\_ /YR

DATE LAST WORKED FOR THIS EMPLOYER: \_\_\_\_\_ /MO \_\_\_\_\_ /DAY \_\_\_\_\_ /YR BODY PART/S INVOLVED RIGHT LEFT (CIRCLE ONE)

EXPLAIN HOW INJURY OCCURRED \_\_\_\_\_

NAME OF CLAIMS ADMINISTRATOR: (INDUSTRIAL INS CO) \_\_\_\_\_ CLAIM# \_\_\_\_\_

YOUR ADJUSTORS NAME: \_\_\_\_\_ PHONE#: AREA CODE ( \_\_\_\_\_ )

EXTENSION \_\_\_\_\_

ADDRESS WHERE CLAIMS ARE MAILED: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

- 8. ( ) Other Type and Cause of Injury (Specify Details)
  
- 9. Have you hired an attorney to represent you regarding this injury? Yes or No  
Lawyer's Name and Phone Number \_\_\_\_\_

10. Your Signature: \_\_\_\_\_

**REVIEW OF SYSTEMS**

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

Have you had a **prior problem** with this same Orthopedic condition in the past?  Y  N (Explain Below)

Do your other joints have:  morning stiffness lasting over 30 minutes  joint pain or swelling  Back Pain  Gout  
 Rheumatoid arthritis  Osteoporosis  prior fracture (which bone) \_\_\_\_\_  None of these

**Have you ever had any of these symptoms?** If no, mark None.

**NONE**

**YEAR**

- 1) GI  Heartburn, ulcers  Nausea, Vomiting  Blood in stool  \_\_\_\_\_  
 Hepatitis  Liver disease
- 2) ENDO  Thyroid Disease  Heat or Cold Intolerance  \_\_\_\_\_
- 3) CON  Weight Loss  Loss of Appetite  \_\_\_\_\_
- 4) EYE  Blurred Vision  Double Vision  Vision Loss  \_\_\_\_\_
- 5) ENT  Hearing Loss  Hoarseness  Trouble Swallowing  \_\_\_\_\_
- 6) CV  Chest Pain  Palpitations  \_\_\_\_\_
- 7) RS  Chronic Cough  Shortness of Breath  \_\_\_\_\_
- 8) GU  Painful Urination  Blood in Urine  Kidney problems  \_\_\_\_\_
- 9) SK  Frequent Rashes  Skin Ulcers  Lumps  Psoriasis  \_\_\_\_\_
- 10) NEU  Headaches  Dizziness  Seizures  \_\_\_\_\_
- 11) PSY  Depression  Drug/Alcohol Addiction  Sleep Disorder  \_\_\_\_\_
- 12) HEM  Easy Bleeding  Easy Bruising  Anemia  \_\_\_\_\_
- 13) ARE YOU HIV POSITIVE:  Y  N

**PAST MEDICAL HISTORY: Circle all that apply**

Are you Diabetic? YES NO If yes, treatment: Insulin Oral Meds Diet None

Are you taking, or have you ever taken, blood thinners? YES NO If yes, which one? \_\_\_\_\_

**PAST SURGICAL HISTORY INCLUDES: (List major surgeries and/or illnesses)**

- 1) \_\_\_\_\_ Date: \_\_\_\_\_ Doctor/State: \_\_\_\_\_
- 2) \_\_\_\_\_ Date: \_\_\_\_\_ Doctor/State: \_\_\_\_\_
- 3) \_\_\_\_\_ Date: \_\_\_\_\_ Doctor/State: \_\_\_\_\_
- 4) \_\_\_\_\_ Date: \_\_\_\_\_ Doctor/State: \_\_\_\_\_

Past Hospitalizations: (Not for Surgery): \_\_\_\_\_  None

Have you ever had: Heart attack (year \_\_\_\_\_) High Blood Pressure Blood Clots (year \_\_\_\_\_) Stroke  
Heart Failure Ankle Swelling Kidney Failure Cancer (location \_\_\_\_\_)

Do you have stomachaches while taking anti-inflammatories (includes Advil/Aleve) \_\_\_\_\_

I do not have any of these conditions

CONTINUED ON FOLLOWING PAGE

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?  
 Diabetes \_\_\_\_\_  High Blood Pressure \_\_\_\_\_  Rheumatoid Arthritis \_\_\_\_\_  
 NONE Do any direct relatives have the same condition you are being seen for today?  Y  N

SOCIAL HISTORY:  
Do you use tobacco?  Y  N If yes, packs per day \_\_\_\_\_ per month \_\_\_\_\_  
Alcohol use?  Y  N If yes, how often?  Daily  Other \_\_\_\_/week  
Do you exercise regularly?  Y  N If yes, how often \_\_\_\_\_  
Current Weight \_\_\_\_\_ Pounds Height \_\_\_\_\_ FT \_\_\_\_\_ IN

CURRENT MEDICATIONS:  
Name: \_\_\_\_\_ Strength: \_\_\_\_\_ per day: \_\_\_\_\_ for: \_\_\_\_\_ Doctor: \_\_\_\_\_  
Name: \_\_\_\_\_ Strength: \_\_\_\_\_ per day: \_\_\_\_\_ for: \_\_\_\_\_ Doctor: \_\_\_\_\_  
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Name: \_\_\_\_\_ Strength: \_\_\_\_\_ per day: \_\_\_\_\_ for: \_\_\_\_\_ Doctor: \_\_\_\_\_

PLEASE SIGN: The information on these forms is accurate to the best of my knowledge.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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FOR OFFICE USE ONLY

Completed \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by \_\_\_\_\_