FRED C. REDFERN, M.D.
ORTHOPEDIC SURGERY
600 WHITNEY RANCH DRIVE, SUITE D-22
HENDERSON, NV 89014
(702) 456-2400

PATIENT INFORMATION

PATIENT: _____ DATE OF BIRTH: _____ AGE: _____

SSN: _____ MARITAL STATUS: M S W D SEX: M F

ADDRESS: _____ CITY:_____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELLULAR PHONE: _____ IN CASE OF EMERGENCY: _____

EMPLOYER NAME: _____ OCCUPATION: _____PHONE NUMBER:_____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

MEDICARE PATIENTS ONLY: PHARMACYNAME:_____

ADDRESS: _____ PHONE:_____

SPOUSE INFORMATION

SPOUSE: _____ D/O/B: _____ SSN: _____

EMPLOYER AND PHONE #: _____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

FATHERS NAME: _____ DATE OF BIRTH: _____ SSN: _____

EMPLOYERS NAME/PHONE #: _____ OCCUPATION: _____

MOTHERS NAME: _____ DATE OF BIRTH: _____ SSN: _____

EMPLOYERS NAME/PHONE #: _____ OCCUPATION: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ PHONE #: _____

INSURED NAME: _____ ID#:_____ GROUP #: _____

SECONDARY INSURANCE: _____ PHONE #: _____

INSURED NAME: _____ ID#: _____ GROUP #: _____

I hereby authorize Fred C. Redfern, M.D. to provide medical treatment to myself or my dependent named above. I authorize Fred C. Redfern, M.D. to bill the above insurance carrier(s) and provide any necessary information concerning my injury/treatment. I hereby assign all payments for medical services rendered to myself or my dependents to Fred C. Redfern, M.D. I understand that my insurance is billed as a courtesy to me. I am responsible for my medical bill whether or not my insurance company pays. I agree and understand that my deductible and co-payments are to paid in full at time of service.

_____ _____

(Patient Signature) Date

Fred C. Redfern, M.D.
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600 Whitney Ranch Drive, Suite #D-22
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MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Who referred you to this office?: _____ Family/Primary Care Physician: _____

LIST OF MEDICATIONS:(Please include: birth control, herbals, vitamins, dietary supplements,and over the counter medication).

I AM NOT TAKING ANY AT THIS TIME _____

ALLERGIES: **I HAVE NO KNOWN ALLERGIES _____**

ALLERGIES TO LATEX: _____ IODINE: _____

YOUR PRESENT HEALTH CONDITIONS:

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
Asthma			Irregular Heart Beat			Liver Disease		
Tuberculosis			Congestive Heart Failure			Skin Disease		
Emphysema/Chronic Bronchitis			Heart Attack			Anemia/Low Red Blood Cells		
Blood Clot in Lung			Heart Murmur			Hepatitis		
Blood Clot in Leg			Rheumatic Fever			HIV		
Blood transfusion			Kidney Stones			Glaucoma		
Bleeding Problems			Gallstones			Cancer, Type		
Arthritis			Prostate Problems					
Gout			Ulcers in Bowels/Stomach			OTHER:		
Anxiety			Bleeding from bowels					
Depression			Kidney Disease					
High Cholesterol			Stroke					
High Blood Pressure			Epilepsy/ Seizures					
Diabetes/High Blood Sugar			Thyroid Problems					

FAMILY HISTORY (Please check appropriate boxes below)

CONDITION	YES	NO	RELATIONSHIP
Heart Attack			
High Blood Pressure			
High Cholesterol			
Liver Disease			
Kidney Disease			
Gout / Arthritis			
Thyroid Problems			
Cancer, TYPE			
OTHER:			

CONDITION	YES	NO	RELATIONSHIP
Osteoporosis			
Stroke			
Asthmas			
Epilepsy / Seizures			
Bleeding Problems			
Sickle Cell Anemia			
Diabetes / High Blood Pressure			
HIV / Hepatitis			

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MEDICAL HISTORY (continue)

Patient Name: _____ Date of Birth: _____

RIGHT HANDED _____ LEFT HANDED _____ HEIGHT _____ WEIGHT _____

SURGERIES: (Please check appropriage boxes below including date)

SURGERIES	DATE	YES	NO	SURGERIES	DATE	YES	NO
Cataract LEFT / RIGHT BOTH				Joint Replacement TYPE:			
Tonsilectomy							
Neck Artery							
Open Heart / Catheterization				Arthroscopic TYPE:			
Appendectomy							
Gallbladder Removal							
Abdominal				Broken Bone/Repair TYPE:			
Vasectomy							
Hysterectomy							
Prostate				Back/Neck TYPE:			
Hernia							
Cosmetic							
Cesarenan Section				OTHER:			
OTHER:							

OTHER HISTORY:

Please describe your physical activity: (circle appropriate selections, be sure to add any that are not listed)

HIKE BIKE GOLF PILATES YOGA SWIM SKI SNOWBOARD RUN/JOG TENNIS

Other: _____

Have you had the following vaccinations? Please circle YES OR NO

Hepatitis A	YES	NO	Tetanus	YES	NO	Year _____	Pneumovax	YES	NO
Hepatitis B	YES	NO					Flu	YES	NO

Nicotine / Alcohol Use

Do you smoke?	YES	NO	Packs _____	Years _____	Quit _____
Do you chew tobacco?			Cans _____	Years _____	Quit _____
Number of Alcholic beverages consumed (on average) in one week?	YES	NO	How much PER DAY? _____		
Have you ever had a substance abuse problem? If yes, please specify	YES	NO			

The above information is current and correct to the best of my knowledge.

_____ _____

Patient Signature Date

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PATIENT'S NAME: _____

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

BODY PART TO BE EXAMINED: _____

IS THIS AN ACCIDENT? YES _____ NO _____ AUTO _____ OTHER _____

DATE ACCIDENT OCCURRED: _____ AM _____ PM _____

HOW DID THE ACCIDENT HAPPEN?:
_____

WHERE DID ACCIDENT OCCUR?:
_____

IS THIS A WORK RELATED INJURY?: **YES _____ NO _____**

Have you, or do you intend to retain an attorney? **YES _____ NO _____**

If yes, please list name,address,and phone of attorney: _____

I understand that such information will be used by my insurance company (s) for the purpose of evaluating my claim benefits and that I or any authorized representative will receive a copy of the authorization upon request. This authorization is valid from date signed through the duration of my treatment with Dr. Redfern.

_____ _____
(Signature of Patient or Responsible Party) (Date)

Fred C. Redfern, M.D.
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge that I have received a
(patient name – please print)

copy of Fred C. Redfern, M.D. "Notice of Privacy Policies". This notice describes how Fred C. Redfern, M.D. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____
(Signature of Patient, or Personal Representative) (Date)

_____
(Relationship to Patient)

_____
(Office Representative)

ACKNOWLEDGEMENT REFUSAL

On this date, the undersigned patient refused or failed to acknowledge receipt of this "Notice of Privacy Policies"

_____ _____
(patient name – please print) (Date)

Reason of refusal/failure: _____

_____
(Office Representative)

Fred C. Redfern, M.D.
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REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name: _____ Date of Birth: _____ Age: _____

SSN: _____ Medical Record #: _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip: _____

Please consider this a request for me to exercise my rights under federal and state laws to request confidential communication of my protected health information.

CHECK ALL THAT APPLY TO THIS REQUEST:

____ Please do not phone me at home. Use this alternate phone number _____.

____ Please do not phone me at work. Use this alternate phone number _____.

____ Please send me mail, including my bills, to this alternate address:

_____

____ Please do not leave messages on my answering machine.

____ Please do not mail missed appointment cards to me.

____ Other

I understand that Fred C. Redfern, M.D. to whom I am making this request will make reasonable efforts to accommodate this request. I understand that I must provide an alternate address to receive bills and statements. I further understand that in some emergency situations, my protected health information may be released.

_____ _____

(Signature of Patient – or Responsible Party) (Date)

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FINANCIAL POLICY:

In today's environment, insurance plans and benefits are in a constant and rapid state of change. Unfortunately, we are not able to be knowledgeable on all aspects of your insurance plans. We ask that you contact your insurance company or human resources department to determine coverage for your health care.

We will seek prior authorization for any diagnostic testing, other procedures or surgeries from your insurance company. Please remember that bills for surgery centers, laboratory tests, diagnostic testing are not controlled by this office. It is your responsibility to contact your insurance company to determine the extent of your financial obligation – i.e. deductibles and co-payments / co-insurance. This helps prevent "surprise health care bills".

We accept Cash, Checks, Visa, MasterCard and Discover as payment. There is a $25 fee for each returned check. There is a $10 fee for completing FMLA and disability forms payable in advance – No Exceptions! Co-payments and Deductibles are due at time of service. If you are not able to pay at time of service, you must contact our office in advance to make payment arrangements. We bill your insurance company as a courtesy to you. Balances not paid by your insurance carrier within 90 days will automatically become your responsibility. You are responsible for understanding your insurance coverage and exclusions and we request that you follow up with any insurance problems that may arise.

You will receive monthly statements and any amounts owed should be submitted promptly. In the event that your account becomes delinquent or a collection account, you agree to pay Fred C. Redfern, M.D. all incurred Finance Charges and Handling Fees. If it is necessary to forward your account to a Collection Agency there will be a markup fee of 35% to 50% of the balance owing.

_____

(Patient Name – Please Print)

_____ _____

(Signature of Patient or Responsible Party) (Date)

Fred C. Redfern, M.D.

Release of Information Policy

Due to increasing regulation surrounding patient privacy, Dr. Redfern's office will not release any information without the signed consent of the patient.

Please use the Medical Records release form to obtain medical information that you wish to have sent to our office. You can use the same form if you wish to have information from our office to be sent to another physician's office.

Please understand that we are unable to give diagnostic testing, laboratory or procedure results over the phone. The reason for this is that we are unable to verify the identity of the patient over the phone. You will be scheduled for an office appointment following your testing to review your results with Dr Redfern.

Given patient confidentiality, we are unable to discuss your medical condition with anyone unless we have your specific written approval. If you have family members or other care givers that participate in your medical care, please have them accompany you to your office visit or please have them schedule an appointment to speak with the physician.

I authorize Dr. Redfern to release medical information about me to the following individuals (upon the presentation of proper identification):

1. _____

2. _____

3. _____

_____ _____

Patient Name (Printed) Birth Date

_____ _____

Patient / Guarantor Signature Date