James D. Dowd, M.D., F.A.C.S.
Mark A. Foreman, M.D.
Joan E. Price, PA-C

American Academy of Orthopedic Surgeons
American College of Surgeons
American Board of Orthopedic Surgery

Dear ____

Thank you for choosing a physician at Greentree Orthopedics. We are highly trained in the treatment of bone and joint injuries and diseases. This confirms your appointment. We look forward to meeting you. Your orthopedic evaluation has been scheduled for (day) ______________ (date) ______________, at _____________ o'clock. Please arrive 15 minutes before appointment time.

So that we may perform a complete evaluation, you will need to prepare for this visit.
Bring five items with you to your appointment:

1. Please fill out the enclosed forms completely. Mail them to the office.
   If the forms have not been **entirely completed**, there will be a delay before you see your doctor.
2. Bring your **previous x-rays and records**, if any, pertaining to your condition or your appointment could be rescheduled. Bring the x-ray film, not the written x-ray reports. It is often necessary to go to the doctor's office or hospital where x-rays were taken to acquire the films.
3. Bring your **insurance cards** so we may photocopy them for our records.
   Bring **payment** for the co-payment or entire bill if you are uninsured.
4. Minors **must** be accompanied by a parent.
5. For hip, leg, or ankle exam, please bring a pair of **shorts** to wear.

We feel it is your responsibility (not the referring doctor or hospital) to insure that these items are available to us at your appointment.

If, for any reason, you will be late or unable to keep your appointment, please let us know in advance.

Please Note Our New Address:
625 SW Ramsey, Suite A
Grants Pass, OR 97527

Thank You!

P.O. Box 5010 • Grants Pass, OR 97527 • Phone: 541-244-2044 • FAX: 541-471-1267

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PAYMENT POLICY

for Greentree Orthopedics, P.C.

Due to increasing delays in patient payments and costs associated with collections,
it is necessary to have the following payment policy.

OFFICE CHARGES

MEDICARE: We are participating providers with Medicare. Deductible portion is due at the time of service. If you have Medicare we will bill your secondary insurance. If you have no secondary insurance, we will collect 20% of the Medicare allowable at time of service.

UNINSURED PATIENTS: Payment is due at time of service on all office charges up to $200. Arrangements must be made in advance for any charges which you are unable to pay above $200.

INSURED PATIENTS: If you have insurance, be prepared to pay co-payments or deductibles which are not covered by the insurance company. No exceptions. It is your responsibility to obtain authorization from your primary care physician for each visit with us.

Insurance may pay all, some or none of your bill. You are responsible for payment regardless of your coverage. Do not keep insurance checks which are issued in payment of service rendered by this practice. No payment plan will be allowed for patients who keep insurance checks.

You will receive a monthly statement of your account.
All past due balances are subject to a late charge of 1.5% per month.

Patient's Signature ______________________________ Date ____________

Approved by ______________________________ Date ____________

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Chief Complaint ____________________________ **OFFICE USE ONLY** DOI ____________________________

Patient Information

Date ____________________________ Referred by ____________________________

Primary Care Physician ____________________________ City ____________________________

PATIENT INFORMATION

Name ____________________________
LAST FIRST MIDDLE

Address ____________________________
STREET CITY STATE ZIP

Billing address if different from above ____________________________

Telephone No. Home ______________ Work ______________ Cell ______________

Age _____ Date of Birth _________ Sex _____ Social Sec. No. ____________ Marital Status _____

If Child: Father's Name ____________________ Mother's Name ____________________

Employer's Name ____________________ Occupation ____________________

Employer's Address ____________________________

Spouse's Name ____________________________

Spouse's Employer Name ____________________ Occupation ______________

Spouse's Employer Address ____________________ Work Phone ______________

Friend or Relative in Oregon Not Living with You

Name ____________________ Relationship ______________

Address ____________________ Telephone ______________

IF ACCIDENT, PLEASE FILL-OUT THIS SECTION

☐ Auto ☐ On the Job ☐ Other Date __________ Time __________ AM PM Work Time Lost ☐ Yes ☐ No

Details ____________________________
WHAT HAPPENED LOCATION

Date Last Worked ____________________________

Are you represented by an attorney regarding your present medical complaint? ______________

____

If the problem for which you are seeing one of our doctors involves litigation, as may result from an automobile accident or fire, be advised that we do not wait for payment until the litigation is settled, but we will accept monthly payment on account.

POLICY HOLDER INSURANCE INFO

Name ____________________ DOB __________ Relationship ______________

Address ____________________________
STREET CITY STATE ZIP

Telephone No. Home ____________________ Business ____________________

Employer's Name ____________________ Social Sec. No. ____________________

Employer's Address ____________________________

INSURANCE INFORMATION

Ins. Co. ______________ I.D. No. ______________ Policy or Group No. ______________

Address ____________________ Employer ______________

Medicare I.D. No. ____________________ Welfare I.D. No. ______________

Ins. Co. ______________ I.D. No. ______________ Policy or Group No. ______________

Address ____________________ Employer ______________

I authorize release of information in my medical history to Medicare and/or my insurance companies and assign all benefits for unpaid services to Greentree Orthopedics, P.C.

Signed ____________________________ Date ______________

CONFIDENTIAL MEDICAL HISTORY

Name ____ Age _________ Date ____________________

PAST MEDICAL HISTORY – If you have had any of these medical problems, please check them and write the date you were first told you had the problem:

_____ Arthritis:
- _____ Degenerative/Osteoarthritis
- _____ Rheumatoid
- _____ Gout
- _____ Other

_____ Muscle injury or disorder
_____ Nerve injury or disorder
_____ Tendon injury or disorder
_____ Back injury or pain
_____ Neck injury or pain
_____ Diabetes
_____ Cancer of any kind
_____ Anemia
_____ Alcoholism
_____ Depression
_____ Tuberculosis
_____ Stroke or Mini-stroke
_____ Thyroid disease
_____ Eye, ear, nose or throat disease
_____ Head injury/concussion
_____ Seizures
_____ High blood pressure
_____ Asthma
_____ Emphysema or chronic bronchitis
_____ Stomach ulcers
_____ Liver disease of hepatitis
_____ Kidney or liver problems
_____ Prostate problems

List all surgeries you have had and give approximate dates:

____

____

____

Have you experienced an unfavorable reaction from any anesthesia, medical or surgical treatment?

_____ Yes _____ No If yes, please describe: ____

____

Any medical or surgical conditions other than those listed above? ___________________________

____

MEDICATIONS – List all of the medication you take. Include aspirin, vitamins, laxatives, birth control pills, tranquilizers, pep pills, sleeping pills, diet pills, etc.

MEDICINE	DOSAGE	HOW OFTEN

CONFIDENTIAL MEDICAL HISTORY

ALLERGIES – List all allergies to medicines:

____

____

FAMILY HISTORY –

	Living (age)	State of Health	Deceased (age)	Cause of Death
Father	________	________	________	________
Mother	________	________	________	________
Brothers	________	________	________	________
	________	________	________	________
Sisters	________	________	________	________
	________	________	________	________
Children	________	________	________	________
	________	________	________	________
	________	________	________	________
	________	________	________	________

SOCIAL HISTORY –

How many hours per week do you work? ______________________________

Married? ______ Yes ______ No If yes, how long? ______________________

Educational level ______________________________

Alcohol? ______ Yes ______ No How much weekly? ______________________

Cigarettes? ______ Yes ______ No _________ packs per day for _________ years.

Street Drugs? ______ Yes ______ No Which ones? ______________________

Hobbies or recreational interests: ______________________________

____

Exercise performed on a regular basis: ______________________________

____

What kind of work do you or did you do? ______________________________

Do you receive disability? ______________ If so, for what? ______________________

Are you retired? ______________________ If so, how long? ______________________

REVIEW OF SYSTEMS

Do you have at the present time any significant disturbance with the following:
(Please answer yes only if the symptoms, problem or complaint has been persistently annoying or has resulted in a definite impairment of your state of well being.)

CONSTITUTIONAL SYMPTOMS

_____ Generalized weakness or fatigue?
_____ Recent weight gain?
_____ Unexplained fever or chills?
_____ Recent weight loss?

HEAD, EYES, EARS, NOSE, THROAT

_____ Frequent or severe headaches?
_____ Unusual mouth or teeth trouble?
_____ Eye injuries or infections?
_____ Hoarseness or change of voice?

CARDIORESPIRATORY

_____ Chest pains?
_____ Become unduly short of breath?
_____ Develop swelling of the ankles?
_____ Excessive sputum or phlegm?
_____ Irregular or rapid heart beat?
_____ Have difficulty breathing when flat?
_____ Chronic cough?
_____ Coughing up blood?

GASTROINTESTINAL

_____ Yellow jaundice?
_____ Dark tarry stools?
_____ Persistent nausea and vomiting?
_____ Abdominal pains?
_____ Red blood in stools?
_____ Vomit blood?

GENITOURINARY

_____ Frequent urination?
_____ Blood in urine?
_____ Painful urination?
_____ Problems with erections (males)?

MUSCULOSKELETAL

_____ Pains in joints?
_____ Back trouble?
_____ Morning stiffness?
_____ Muscle aching?
_____ Leg pains during exercise?
_____ Frequent or severe muscle cramps?
_____ Joint swelling or redness?

NEUROLOGIC

_____ Weakness or paralysis?
_____ Numbness?
_____ Shakiness, tremor or nervousness?
_____ Pins and needles sensations?

HEMATOLOGIC

_____ History of blood transfusions?
_____ Bleeding tendency?
_____ Easy bruising?
_____ Frequent infections?

DERMATOLOGIC

_____ Unusual dark spots or pigmented areas?
_____ Hypersensitivity to sunlight?
_____ Chronic rash or other skin problems?

FOR FEMALES ONLY

_____ Breast lump, pain or discharges?
_____ Could you be pregnant now?