TOMAN ORTHOPEDICS
AND SPORTS MEDICINE

CHARLES V. TOMAN, M.D.
Board-Certified. Fellowship-Trained. Orthopedic Surgeon

Please fill out the entire form. If a question does not pertain to you please write N/A (non-applicable)

Last Name: _____ **First Name:** _____ **DOB:** _____

Sex: M / F **S.S. #:** _____ **Marital Status:** ___Married ___Single ___Divorced ___Widowed

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

Email: _____ **Home Phone:** _____ **Cell:** _____

DUE TO RECENT REFORMS MANDATED BY THE GOVERNMENT, DOCTORS ARE REQUIRED TO ASK ALL PATIENTS FOR THEIR RACE AND ETHNICITY REGARDLESS OF INSURANCE TO MEET MEANINGFUL USE REQUIREMENTS.

Race:

- ☐ American Indian/Alaskan
- ☐ Asian
- ☐ African American
- ☐ Hawaiian/Pacific Islander
- ☐ Hispanic
- ☐ White
- ☐ Other Race _____
- ☐ Decline to Provide Information

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to Provide Information

Preferred Language:

- ☐ Creole
- ☐ English
- ☐ Spanish
- ☐ Other _____

Pharmacy: _____ **Pharmacy #:** _____ **Location:** _____

Primary Insurance: _____ **Policy Holder:** _____ **DOB:** _____

7301A West Palmetto Park Road • Suite 100B • Boca Raton, FL 33433
PHONE 561.221.6895 **FAX** 561.221.6896 **WEB** tomanortho.com

TOMAN ORTHOPEDICS
AND SPORTS MEDICINE

CHARLES V. TOMAN, M.D.
Board-Certified. Fellowship-Trained. Orthopedic Surgeon

CHIEF COMPLAINT: _____
(WHAT BRINGS YOU IN TODAY?)

REFERRING PHYSICIAN: _____
(WHICH DOCTOR SENT YOU TO US?)

CURRENT MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY

- ☐ ANEMIA, CHRONIC
- ☐ ANXIETY
- ☐ ASTHMA
- ☐ BREAST CANCER
- ☐ CHRONIC PAIN
- ☐ COLON CANCER
- ☐ COPD
- ☐ CORONARY ARTERY DISEASE
- ☐ DEPRESSION
- ☐ DIABETES, INSULIN DEPENDENT
- ☐ DIABETES, NON INSULIN DEPENDENT
- ☐ HYPERTENSION
- ☐ HYPERTHYROIDISM
- ☐ HYPOTHYROIDISM
- ☐ LUNG CANCER
- ☐ PACEMAKER
- ☐ SEIZURES
- ☐ STROKE
- ☐ VITAMIN D DEFICIENCY
- ☐ OTHER

_____

7301A West Palmetto Park Road • Suite 100B • Boca Raton, FL 33433
PHONE 561.221.6895 **FAX** 561.221.6896 **WEB** tomanortho.com

TOMAN ORTHOPEDICS
AND SPORTS MEDICINE

CHARLES V. TOMAN, M.D.
Board-Certified. Fellowship-Trained. Orthopedic Surgeon

PLEASE STATE ANY PAST SURGICAL HISTORY IN DETAIL (WHEN/WHERE...?)

_____

_____

_____

ORTHOPEDIC HISTORY

PLEASE CHECK ALL THAT APPLY

- ☐ ANKLE FRACTURE
- ☐ BURSITIS
- ☐ EPIDURAL INJECTIONS, SPINE
- ☐ GOUT
- ☐ HIP FRACTURE
- ☐ METASTATIC BONE DISEASE
- ☐ OSTEOARTHRITIS
- ☐ OSTEOPENIA
- ☐ OSTEOPOROSIS
- ☐ PRIMARY BONE SARCOMA
- ☐ RHEUMATOID ARTHRITIS
- ☐ RICKETS
- ☐ SCIATICA
- ☐ SCOLIOSIS
- ☐ SPINE FRACTURE
- ☐ SPINAL STENOSIS, CERVICAL
- ☐ SPINAL STENOSIS, LUMBAR
- ☐ VITAMIN D DEFICIENCY
- ☐ WRIST FRACTURE
- ☐ OTHER:

_____

_____

_____

7301A West Palmetto Park Road • Suite 100B • Boca Raton, FL 33433
PHONE 561.221.6895 **FAX** 561.221.6896 **WEB** tomanortho.com

TOMAN ORTHOPEDICS
AND SPORTS MEDICINE

CHARLES V. TOMAN, M.D.
Board-Certified. Fellowship-Trained. Orthopedic Surgeon

FAMILY HISTORY

☐ DIABETES
☐ HYPERTENSION
☐ OSTEOPOROSIS
☐ SCOLIOSIS
☐ OTHER

_____
_____
_____

PROVIDE ALL MEDICATIONS IN THIS COLUMN

_____
_____
_____
_____
_____
_____

PROVIDE ALL ALLERGIES IN THIS COLUMN

_____
_____
_____
_____
_____
_____

IF YOU HAVE A PHYSICAL COPY OF YOUR MEDICATION LIST, PLEASE PROVIDE TO THE MEDICAL ASSISTANT SO THAT WE CAN SAVE A COPY TO YOUR RECORDS

SOCIAL HISTORY

☐ CURRENT SMOKER
☐ FORMER SMOKER
☐ NEVER BEEN A SMOKER

7301A West Palmetto Park Road • Suite 100B • Boca Raton, FL 33433
PHONE 561.221.6895 **FAX** 561.221.6896 **WEB** tomanortho.com

TOMAN ORTHOPEDICS
AND SPORTS MEDICINE

CHARLES V. TOMAN, M.D.
Board-Certified. Fellowship-Trained. Orthopedic Surgeon

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use of disclosure of any protected health information by C. Toman, MD LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of C. Toman, MD LLC. I understand that diagnosis or treatment of me by C. Toman, MD LLC may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used of disclosed to carry out treatment or payment of healthcare operations of the practice. C. Toman, MD LLC is not required to agree to the restrictions that I may request. However, if C. Toman, MD LLC agrees to a restriction that I requested the restriction is binding on C. Toman, MD LLC.

I have the right to revoke this consent in writing, at any time, except to the extent that C. Toman, MD LLC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe this information may identify me.

I understand I have a right to review C. Toman, MD LLC Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me if requested. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of C. Toman, MD LLC. The Notice of Privacy Practices for C. Toman, MD LLC also describes my rights and the duties of C. Toman, MD LLC with respect to my protected health information.

C. Toman, MD LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy by asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Guardian Date

_____

Printed Name of Patient or Guardian

7301A West Palmetto Park Road • Suite 100B • Boca Raton, FL 33433
PHONE 561.221.6895 **FAX** 561.221.6896 **WEB** tomanortho.com

TOMAN ORTHOPEDICS
AND SPORTS MEDICINE

CHARLES V. TOMAN, M.D.
Board-Certified. Fellowship-Trained. Orthopedic Surgeon

PRINT PATIENT NAME _____ DATE _____

MEDICAL NECESSITY STATEMENT

PROVIDER NOTICE TO BENEFICIARY REGARDING SERVICE(S) THAT MAY POSSIBLY BE DENIED BY YOUR INSURANCE AS "NOT REASONABLE AND NECESSARY."

YOUR INSURANCE WILL ONLY PAY FOR SERVICES THAT IT DETERMINES TO BE "REASONABLE" AND "NECESSARY" UNDER SECTION 1862 (A) (1) OF THE MEDICARE LAW. IF YOUR INSURANCE DETERMINES THAT A PARTICULAR SERVICE, ALTHOUGH IT WOULD OTHER WISE BE COVERED, IS "NOT REASONABLE AND NECESSARY" UNDER THEIR PROGRAM STANDARDS, THE INSURANCE WILL DENY PAYMENT FOR THAT SERVICE.

I HAVE BEEN NOTIFIED THAT IN MY CASE THAT MY INSURANCE MAY DENY PAYMENT FOR THESE SERVICES. **IF PAYMENT IS DENIED, I AGREE TO BE FULLY RESPONSIBLE FOR PAYMENT.**

_____
Signature of Patient or Guardian

_____
Office Personnel Signature (Witness)

7301A West Palmetto Park Road • Suite 100B • Boca Raton, FL 33433
PHONE 561.221.6895 **FAX** 561.221.6896 **WEB** tomanortho.com

TOMAN ORTHOPEDICS
AND SPORTS MEDICINE

CHARLES V. TOMAN, M.D.
Board-Certified. Fellowship-Trained. Orthopedic Surgeon

TOMAN ORTHOPEDICS AND SPORTS MEDICINE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know our office policy in advance allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. Toman Orthopedics accepts cash, checks, Visa, Mastercard, American Express and Discover. There is a service charge for returned checks.

Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of the receipt of your bill.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments.

INSURANCE:

We bill participating insurance companies. You are expected to pay your deductible and copayments at the time of service, this includes payment prior to any surgical procedures. If we have not received payment from your insurance company within 45 days of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

I have read and understand the Toman Orthopedics and Sports Medicine Financial Policy. I agree to assign insurance benefits to Toman Orthopedics whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for the cost of collections.

Signature of patient or authorized representative: _____

Date: _____

7301A West Palmetto Park Road • Suite 100B • Boca Raton, FL 33433
PHONE 561.221.6895 **FAX** 561.221.6896 **WEB** tomanortho.com