

**VALLEY ORTHOPEDICS, P.L.C.**  
**Grant D Padley D.O.**

**Patient History (To be filled out by patient)**

Date: \_\_\_/\_\_\_/\_\_\_ Name: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Who referred you to our practice? \_\_\_\_\_

**Chief Complaint:**

Right  Left  Both       Shoulder  Elbow  Knee  Other: \_\_\_\_\_

Reason for today's visit (describe symptoms)? \_\_\_\_\_

Was this due to an injury?  No  Yes, describe how this occurred \_\_\_\_\_

Date of Injury: \_\_\_/\_\_\_/\_\_\_ Injury Occurred:  Playing a Sport  At Work  Other:

**Check all the limitations below that apply to your injury and/or symptoms:**

\_\_\_\_\_ Prolong Walking \_\_\_\_\_ Prolong Sitting \_\_\_\_\_ Prolong Standing \_\_\_\_\_ Stooping  
\_\_\_\_\_ Pushing/Pulling \_\_\_\_\_ Up/Down Steps \_\_\_\_\_ Lying Down \_\_\_\_\_ Grasping  
\_\_\_\_\_ Lifting \_\_\_\_\_ Bending \_\_\_\_\_ Flexion \_\_\_\_\_ Extension \_\_\_\_\_ Giving Out  
\_\_\_\_\_ Any Weight Bearing \_\_\_\_\_ Any Use Of \_\_\_\_\_

**PAST MEDICAL HISTORY** (*Have you ever had any of the following in the past?*)

- |   |  |
|---|--|
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Blood Clots   |
| <input type="checkbox"/> Heart Murmur   | <input type="checkbox"/> Any Bleeding Disorder   |
| <input type="checkbox"/> Heart Attack   | <input type="checkbox"/> Frequent Bleeding nose or gums  |
| <input type="checkbox"/> Heart Surgery  | <input type="checkbox"/> Cramping in legs when walking   |
| <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Varicose Veins  |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Seizures or Stroke  |
| <input type="checkbox"/> Emphysema/COPD   | <input type="checkbox"/> Psychiatric (any mental disorder)   |
| <input type="checkbox"/> Bowel Disorder   | <input type="checkbox"/> Cancer  |
| <input type="checkbox"/> Stomach Ulcers   | <input type="checkbox"/> <input type="checkbox"/> Benign <input type="checkbox"/> <input type="checkbox"/> Malignant |
| <input type="checkbox"/> Blood in stools  | <input type="checkbox"/> Osteoporosis  |
| <input type="checkbox"/> Bladder or Urinary Infections  | <input type="checkbox"/> Muscular skeletal disorder  |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Recurrent Infections  |
| <input type="checkbox"/> <input type="checkbox"/> Insulin <input type="checkbox"/> Oral Med <input type="checkbox"/> Diet | <input type="checkbox"/> Slowly healing wounds   |
| <input type="checkbox"/> Thyroid Problems   | <input type="checkbox"/> Fractures   |
| <input type="checkbox"/> <input type="checkbox"/> Hyper <input type="checkbox"/> <input type="checkbox"/> Hypo            | If yes, which bone and when?   |

**NORMAL, I've had none of the above.**

**PAST SURGICAL HISTORY:**

Surgery(s) If yes, list procedure, body part, and when?

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**SOCIAL HISTORY:**

Do you smoke? \_\_\_\_\_ packs per day? \_\_\_\_\_ how many years? \_\_\_\_\_

Drug use? \_\_\_\_\_

Alcohol use? \_\_\_\_ None Rarely Socially Moderate

Occupation: \_\_\_\_\_ Full Duty Light Duty Not Working

Student \_\_\_\_ No \_\_\_\_ Yes

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Sports/activities: \_\_\_\_\_

**FAMILY HISTORY:**

Does any family member have a history of any of the following: (check all that apply)

- |                           |                                    |
|---------------------------|------------------------------------|
| _____ Heart Disease       | _____ Lung Disease                 |
| _____ Cancer              | _____ Diabetes                     |
| _____ Thyroid Disease     | _____ Hypertension                 |
| _____ Asthma              | _____ Tuberculosis                 |
| _____ Arthritis           | _____ Hay Fever/Seasonal Allergies |
| _____ Parkinson's Disease | _____ Bronchitis                   |
| _____ Other _____         | _____ None of the above.           |

**MEDICATIONS:**

Are you taking any medications, herbs, or vitamins? (Please list)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:**

Are you allergic to any medications  No  Yes

If yes, which ones?

\_\_\_\_\_

What happens?

\_\_\_\_\_

**FEMALES ONLY:**

Are you pregnant?  Yes  No

Have you had a baby within the last month?  Yes  No

Are you currently taking birth control pills?  Yes  No How long? \_\_\_\_\_

Are you on hormone therapy?  Yes  No Name: \_\_\_\_\_ Dose: \_\_\_\_\_

**REVIEW OF SYSTEMS: (PLEASE CIRCLE SPECIFIC COMPLAINT):**

- |                      |        |                           |        |
|----------------------|--------|---------------------------|--------|
| Heart Disease/Stroke | No Yes | Ears,Nose,Throat,Eyes     | No Yes |
| Lungs, Breathing     | No Yes | Digestive Problems/Ulcers | No Yes |
| Emphysems/Asthma     | No Yes | Bladder Problems          | No Yes |
| Diabetes             | No Yes | High Blood Pressure       | No Yes |
| Bleeding Problems    | No Yes | Elevated Cholesterol      | No Yes |
| Numbness/Tingling    | No Yes | Fainting/Balance Problems | No Yes |
| Depression/Anxiety   | No Yes | AIDS/TB/Hepatitis         | No Yes |

Normal, I have had none of the above recently

# PATIENT REGISTRATION FORM

PATIENT NAME: \_\_\_\_\_ RESPONSIBLE PARTY NAME: \_\_\_\_\_ BILLING  
ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_

PERMANENT ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

PT SOC SEC#: \_\_\_\_\_ RESP PARTY SOC SEC# \_\_\_\_\_  
SEX: MALE FEMALE

PT BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ RESP PARTY RELATIONSHIP TO PT: SELF SPOUSE CHILD OTHER  
(PLEASE CIRCLE OPTION)

E-MAIL ADDRESS: \_\_\_\_\_

WHO REFERRED YOU TO OUR PRACTICE?: \_\_\_\_\_

WHAT IS YOUR PRIMARY CARE PHYSICIANS FULL NAME?: \_\_\_\_\_

WHAT ARE YOU BEING SEEN FOR?: \_\_\_\_\_

IF YOUR VISIT IS INJURY RELATED, WAS IT: AN AUTO ACCIDENT OR JOB RELATED? DATE OF INJURY: \_\_\_\_\_  
(PLEASE CIRCLE OPTION)

IS PATIENT: SINGLE MARRIED WIDOWED DIVORCED OTHER IS PATIENT PREGNANT: YES NO  
(PLEASE CIRCLE OPTION)

IS PATIENT: EMPLOYED RETIRED F.T./P.T. STUDENT UNEMPLOYED SELF-EMPLOYED OTHER  
(PLEASE CIRCLE OPTION)

EMPLOYER NAME/ADDRESS/PHONE#: \_\_\_\_\_

NEAREST RELATIVE OR FRIEND NAME/PHONE#: \_\_\_\_\_  
(SOMEONE OTHER THAN YOUR SPOUSE)

## INSURANCE INFORMATION

PRIMARY INSURANCE: \_\_\_\_\_ SECONDARY INSURANCE: \_\_\_\_\_  
INSURANCE CO. NAME: \_\_\_\_\_ INSURANCE CO. NAME: \_\_\_\_\_

INSURANCE ADDRESS: \_\_\_\_\_ INSURANCE ADDRESS: \_\_\_\_\_

POLICY HOLDER NAME: \_\_\_\_\_ POLICY HOLDER NAME: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

SUBSCRIBER ID#: \_\_\_\_\_ SUBSCRIBER ID#: \_\_\_\_\_

GROUP/CLAIM#: \_\_\_\_\_ GROUP/CLAIM#: \_\_\_\_\_

POLICYHOLDER SEX: F OR M BIRTHDATE: \_\_\_\_\_ POLICYHOLDER SEX: F OR M BIRTHDATE: \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:** I HEREBY AUTHORIZE VALLEY ORTHOPEDICS, P.L.C. TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT WHICH COULD INCLUDE HIV, COMMUNICABLE DISEASE OR DRUG ABUSE INFORMATION.

**AUTHORIZATION TO PAY:** I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BUSINESS OFFICE OF WEST VALLEY ORTHOPEDICS, P.L.C. FOR THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY MY INSURANCE.

PATIENT OR RESPONSIBLE PARTY SIGNATURE IF MINOR: \_\_\_\_\_

DATE SIGNED: \_\_\_\_\_

# VALLEY ORTHOPEDIC, P.L.C.

13555 W. McDowell Rd., Suite 302, Goodyear, AZ 85395  
9250 N. 3<sup>rd</sup> Street, Suite 2030, Phoenix, AZ 85020  
Phone: 623-882-1292 Fax: 623-932-1045

LAWRENCE SHANK, M.D.    GREGORY SIROUNIAN, M.D.    DOUGLAS MANGAN, M.D.  
GRANT PADLEY, D.O.    KRIS PARCHURI, D.O.  
MICHELLE KUHN, P.A.-C.    JULIE PERRY P.A.-C.

## OFFICE POLICY EFFECTIVE IMMEDIATELY

- No patients under the age of 18 will be seen in our office without a written note from legal guardian.
- In the event a patient is unable to keep their scheduled medical appointment with their provider, a phone call must be received by our office 24 hours prior to appointment; otherwise an automatic \$25.00 administrative fee may be charged to the patient account.
- We do not bill for co-pays. **PAYMENT IS EXPECTED AT DAY OF SERVICE.**
- Should a patient leave a message with our office, they can anticipate a return call with 24 hours.
- No pain medications or routine medications will be called in by the **ON CALL PROVIDER**. Patients will have to wait until the next working day to discuss with their provider.
- All patients are responsible for making their follow-up appointments and must arrive on time.
- Any patient that arrives 15 minutes after their scheduled appointment may be asked to reschedule. If the patient must be seen secondary to an acute illness, he/she may have to wait to be seen by another provider after his/her case has been reviewed.
- Walk-in patients will be seen only with the provider's authorization.
- At no time, will medical information be shared with another individual/party unless explicitly specified by the patient. ( A consent form providing authorization to release medical information must be signed).
- **This office is not responsible for your insurance benefits.** Should a diagnostic test and/or procedure be recommended by your provider but is **NOT** covered by your insurance, you will be responsible for **ALL CHARGES**: This also includes charges related to "weight or obesity management".
- If the medical provider feels that you need further diagnostic work up (xrays, etc) or refers to a specialist, it is your responsibility to ensure that those test and/or office visits are completed.
- **AT NO TIME** will inappropriate language be tolerated while on the premises or by phone to any of West Valley Orthopedics staff.
- If a patient misses 3 visits within a year, West Valley Orthopedics reserves the right to discontinue the provider-patient relationship. A letter will be sent to the patient to notify of such.

I \_\_\_\_\_ have read Valley Orthopedics, office policy. I will have a copy only if I asked for one. I agree to follow this policy at all times.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Printed Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**VALLEY ORTHOPEDICS, P.L.C.**  
**FINANCIAL POLICY FORM**

**Valley Orthopedics, P.L.C., the office of Lawrence P. Shank, M.D., P.C., Gregory H. Sirounian, M.D., P.C., Douglas B. Mangan, M.D., P.C., Grant D. Padley, D.O., Kris Parchuri, D.O. expects payment of your care at the time of service. However, with all verifiable insurance information you will only be expected to pay the deductible, co-payment, co-insurance, or those services not covered or allowed by your insurance.**

It is our policy to bill your insurance carrier as a courtesy to you, although you are ultimately responsible for the entire charge when services are rendered. If your insurance carrier does not remit payment within 45 days from the date of service, the balance will be due in full from you. Since we may not be a party to the agreement with you insurance carrier, it is not our policy to contact carriers to establish why they have not paid or why they paid less then originally indicated. Furthermore, your insurance company may have developed a reasonable and customary fee schedule for medical services. These schedules are internal to your insurance company and they may or may not cover all charges incurred during your treatment. These fee schedules often do not reflect standard charges in our geographic area. Please be advised that you are responsible for the total charges or any difference remaining following the payment by your insurance company. Exceptions, if your insurance company is one that **VALLEY ORTHOPEDICS, P.L.C.** participates or holds a contract with, you are only responsible for any patient portion or non-covered service as determined by your insurance carrier.

The above statements do not apply to those patients who are considered **Worker's Compensation**. However, please be advised that as an Industrial Patient, that you may be held responsible for your charges in the event your claim is controverted.

If you fail to make any payments for which you are deemed responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by **VALLEY ORTHOPEDICS, P.L.C.** you will be responsible for all costs of collecting moneys owed, including but not limited to court costs, collection agency and/or attorney fees.

Your signature below indicates that you have read the above information and authorize direct payment from your insurance carrier to **VALLEY ORTHOPEDICS, P.L.C.** and that you understand the financial policy of **VALLEY ORTHOPEDICS, P.L.C.** as it relates to your account.

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**Patient or Responsible Party**

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**Date Signed**

**Authorization for release of medical information to the insurance carrier and assignment of benefits to the physician.**

I hereby authorize the release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to **VALLEY ORTHOPEDICS, P.L.C.** I understand that I am financially responsible for any balance not covered by my insurance carriers. A copy of this signature is as valid as the original.

**Signature of patient or legal guardian of patient** \_\_\_\_\_

**13555 W. MCDOWELL RD., Suite 302, GOODYEAR, AZ 85395**  
**9250 N. 3<sup>rd</sup> Street, Suite 2030, Phoenix, AZ 85020**  
**PHONE: (623) 882-1292 FAX: (623) 882-8184**

# VALLEY ORTHOPEDICS

## PATIENT COMMUNICATION SHEET

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

DATE: \_\_\_\_\_

The following instructions pertain to the above named patient:

\_\_\_\_\_ OK to call home and leave message.

\_\_\_\_\_ Do not leave message.

\_\_\_\_\_ Do not call home phone- call only this number.  
(\_\_\_\_\_) \_\_\_\_-\_\_\_\_

\_\_\_\_\_ Do not call work number.

\_\_\_\_\_ Call work number only.

\_\_\_\_\_ Permission to speak only with family members listed below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Do not speak to family members.

Patient or responsible party signature: \_\_\_\_\_