

Patient Name: _____ SSN: _____

Address: _____
Street City State Zip

Home #: _____ Birth Date: _____ Age: _____ Sex: Male Female

Marital Status: Single Married Divorced For x-ray purposes, are you pregnant? Yes No

Patient's Employer: _____ Employer Phone #: _____

Employer's Address: _____
Street City State Zip

Spouse's Name or if minor, parent or guardian's name: _____

SSN & Birthdate of spouse or parent or guardian: _____

Reason for today's visit: _____

Is this a work-related? _____ If yes, give date occurred: _____

Did you go to the Emergency Room? Yes No If yes, give hospital name: _____

Date of treatment _____ Were x-rays taken? Yes No

If you were referred by another doctor for today's problem, give Doctor's Name: _____

Are you seeking a second opinion for today's problem? Yes No

Name and address of Family Doctor: _____

INSURANCE INFORMATION – PLEASE PRODUCE YOUR INSURANCE CARD FOR US TO SCAN TO OUR FILES

Primary Insurance Company: _____

Named of Insured: _____ Relationship to patient: _____

Employer of Insured: _____

SS # and Birthdate of Insured: _____

Secondary Insurance Company: _____

Named of Insured: _____ Relationship to patient: _____

Employer of Insured: _____

SS # and Birthdate of Insured: _____

Acceptance of financial responsibility: I understand that I am responsible for all medical expenses regardless of insurance coverage and whether or not there is an accident with another person at fault. Authorization to treat and to release medical information: I hereby authorize medical treatment and the release of medical information requested from my insurance company. Authorization to pay: I hereby authorize payment directly to Carolina Orthopaedic and Sports Medicine Center, P.A.

Signature of patient, parent or guardian: _____ Date: _____

Patient Name: _____

DATE OF ACCIDENT: _____

Type of Accident: Auto Work Related Other

If work related, give name & phone # of person who will verify: _____

How and when did the accident happen? _____

Patient Signature

Date

Name _____ Date of birth ____/____/____ Sex M F

List Drug Allergies _____

PAST MEDICAL HISTORY - Have you ever been diagnosed with any of the following? (check)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Disease/Stone | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Stomach/Intestinal Ulcers | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Heart Murmur/Irreg. Rate | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Enlarged Heart/CHF | <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Intestinal Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/AIDS |

Other illnesses _____

CURRENT MEDICAL PROBLEMS - List all conditions currently being treated

1. _____ 3. _____
2. _____ 4. _____

CURRENT MEDICATIONS - List names, dosage, and times per day. Include nonprescription drugs also.

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

REVIEW OF SYSTEMS - Are you currently having or have you had problems with your:

Circle Describe all YES responses

Eyes	NO	YES	_____
Ears, Nose, Throat	NO	YES	_____
Lungs, Breathing	NO	YES	_____
Digestion	NO	YES	_____
Bowel Movement	NO	YES	_____
Bladder Problem	NO	YES	_____
Balance Problems	NO	YES	_____
Numbness/tingling	NO	YES	_____
Weakness	NO	YES	_____
Blackout/fainting	NO	YES	_____

LIST OPERATIONS - (Give date or age)

FAMILY HISTORY - Have any of your relatives (parent, grandparent, brother or sister) had (check)

- Heart Disease Arthritis Diabetes Bleeding Disorders Sickle Cell Anemia

IMMUNIZATIONS - (Approximate date or age) Flu _____ Tetanus _____

HABITS

Tobacco (cigarettes, cigars, chewing tobacco)

Alcohol use (beer, wine, liquor)

Yes	No	Amount

HAVE YOU EVER HAD A BONE DENSITY STUDY?

YES NO If yes, when? _____

Patient Signature _____ Date _____

Reviewed By _____ MD Date _____

Carolina Orthopaedic & Sports Medicine Center, P.A.

for fitness. for fun. for life.

GUIDELINES FOR PRESCRIPTION REFILLS

1. Our office requires a **24-hour notice for prescription refills.**
2. Medications will be refilled between **9 AM and 4 PM Monday – Friday.** **No refills on the weekends or holidays. The “on-call” physician will not refill medications.**
3. Safety of your prescriptions is YOUR responsibility. **LOST PRESCRIPTIONS WILL NOT BE REFILLED.** Lock up your prescriptions medicines and keep them away from children.
4. Our physicians may not refill prescriptions for pain medicine if you are receiving similar medicines from another physician.
5. Be aware of the effect of other medications you may be taking. Ask your doctor or your pharmacist whether you can take them along with pain medication.
6. Do not drink alcoholic beverages while taking pain medication. Obey warnings regarding sedation of certain medicines.
7. Follow the prescribed dose of the medication. Do not give your medications to other people and do not take medication from others.

I agree and will comply with the above guidelines.

Signature of patient, parent, or guardian: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

Chart #: _____ Date of Birth: _____

Patient Name (*please print*): _____

I have been offered a copy of the Notice of Privacy Practices for Carolina Orthopaedic & Sports Medicine Center, P.A.

Signature

Date

Authorization for Release of Information

Name & Address of Covered Entity Authorized to Release Information:

**CAROLINA ORTHOPAEDIC & SPORTS MEDICINE CENTER, P.A.
620 SUMMIT CROSSING PLACE, SUITE 108
GASTONIA, NC 28054**

The above name entity is authorized to disclose protected health information to the entities named below.

Entity to Receive Information. Initial each that is subject to this authorization.

_____ Leave information on the voice mail.

_____ Leave information with my spouse.

_____ Leave information with the following persons: _____

Description of information to be released.

Information results from any tests or xrays.

Other information as described: _____

This authorization shall be in force and effect until revoked by the patient or representative or representative signing the authorization.

The permitted use of the information is to inform the patient.