GUILFORD ORTHOPAEDIC AND SPORTS MEDICINE CENTER

Southeastern Orthopaedic Specialists

Date: _____ Chart # _____ Provider _____

Patient Name (Please Print) _____

Patient Signature _____

BP ___/___ Pulse _____
Temp _____ H ___/___ W ___

Date of Birth ___/___/___ Age ___ ☐ F ☐ M Height ___/___ Weight _____

Who requested that you visit this office? ☐ Doctor (Name) ☐ Self-Referral ☐ Attorney

Primary Care Physician: _____ Occupation: _____

* What is the main reason for this visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Other _____ (Chief Complaint)

* **What body part is involved? (Location)**

Neck ☐		Shoulder	☐ R ☐ L	Elbow	☐ R ☐ L	Hand	☐ R ☐ L	Pelvis	☐ R ☐ L	Knee	☐ R ☐ L	Foot	☐ R ☐ L
Back ☐ Mid ☐ Lower		Arm	☐ R ☐ L	Wrist	☐ R ☐ L	Finger	☐ R ☐ L	Hip	☐ R ☐ L	ankle	☐ R ☐ L	Toe	☐ R ☐ L

How long has this problem been present? _____ ☐ Days ☐ Weeks ☐ Months

Check the box which best fits how your problem started. Then answer the one question below the box you checked. Use as much space to the right as needed.

☐ **NO INJURY (Onset was:** ☐ Gradual or ☐ Sudden) **ANSWER:**
Why do you think it started?

INJURY - (NOT AUTO OR WORK)
Date _____, Where and How did it Happen?

INJURY AT WORK
Date _____, Where and How did it Happen?

WORK RELATED - (BUT NO INJURY)
Date _____, Where and How did it Happen?

AUTO ACCIDENT - Date / Details -
Driver / Passenger taken to ER?

Please check the box below which best describes your problem:

The pain is ☐ Constant ☐ Comes and goes (Intermittent) (Duration)

Severity of pain ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely Severe (Severity)

What is the **quality** of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Other: _____ (Quality)

Are these associated symptoms? ☐ Swelling ☐ Numbness ☐ Weakness (Assoc Symp)

Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged (Context)

Does your pain wake you from sleep? ☐ Yes ☐ No (Timing)

What makes your symptoms **worse**? ☐ Activity ☐ Exercise ☐ Work ☐ Other _____ (Modify)

Which make you feel better? ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Other _____ (Modify)

What medications have you taken or been prescribed for this problem? _____ (Modify)

Check which treatments you have tried: Injection ☐ Y ☐ N Brace ☐ Y ☐ N Therapy ☐ Y ☐ N Cane/Crutch ☐ Y ☐ N (Modify)

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INITIAL HISTORY TAKER™

^ Minimum dictation required for New/Consult Level 3,4,5 or Established Level 3,4,5
Recommended for all dictation levels for New, Consult or Established 1-5

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GUILFORD ORTHOPAEDIC AND SPORTS MEDICINE CENTER

Health History New Patient

I certify that the following information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may make in the completion of this form.

Patient Name (Print: First, Middle, Last)	*Patient Signature*	*Date*

What is your age?		What hand do you write with?	☐ Right ☐ Left

List **ALL** your **Diagnosed Medical Problems** *(not just those related to your current office visit)*		
✓*if true*		I have no known medical problems.

Medications: list ALL that you are currently taking.			**Allergies:** list ALL medications and foods allergies.		
✓*if true*		I take no medications currently.	✓*if true*		I have no known allergies.

List **ALL** prior **operations or surgeries** you have had (include dates if known).		
✓*if true*		I have not had any surgery in the past.

List **ALL** medical problems in your family or blood relatives: *(list the member affected by the medical problem).*		
✓*if true*		There are no known medical problems in my family.

GUILFORD ORTHOPAEDIC
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Please answer the following questions	✓ yes	✓ no
Do you smoke cigarettes?		
If so, how many packs per day?		
How many years have you been smoking?		
Do you smoke a pipe or cigars?		
Do you dip snuff or chew tobacco?		
Do you drink alcohol?		
How often and how much alcohol do you drink?		
Do you use any street drugs?		
If so, which drugs do you use?		
Who do you live with?		

REVIEW OF SYSTEMS (ROS)

Please ✓ symptoms you currently have or have had in the past year

	General		Eye, Ear, Nose, Throat		Musculoskeletal		Psychiatric
	Fevers or Chills		Difficulty swallowing		Joint pains		Anxiety
	Dizziness		Hearing loss		Muscle aches		Depression
	Fainting spells		Hoarseness		Ankylosing spondylitis		Psychiatric hospitalization
	Fatigue		Nose bleeds		Weak bones		Panic attacks
	Frequent headaches		Ringing in ears		Rheumatoid arthritis		Suicidal thoughts
	Insomnia		Sinus problems		Osteoarthritis		Psychiatric drugs
	Sweats		Vision-blurred		Bone cancer		Memory loss
	Weight changes		Poor vision		Bone infections		Other:
	Other:		Other:		Other:		**MEN only**
	Cardiovascular		**Gastrointestinal**		**Genito-Urinary**		Breast lumps
	Ankle swelling		Poor appetite		Bladder control		Enlarged prostate
	Chest pains		Bowel changes		Blood in urine		Erectile dysfunction
	Enlarged heart		Constipation		Frequent urination		Penis discharge
	Heart attack		Diarrhea		Kidney stones		Prostate cancer
	Heart murmur		Excessive thirst		Painful urination		Other:
	Heart palpitations		Heartburn		Urgent urination		**WOMEN only**
	High blood pressure		Nausea		Weak stream		Abnormal Pap Smear
	Shortness of breath		Rectal bleeding		Other:		Breast Lumps
	Irregular heart beat		Stomach pain		**Neurological**		Vaginal Discharge
	Prolonged bleeding		Ulcers		Loss of fine motor control		Severe menstrual pain
	History of blood clots		Vomiting		Weakness		Hot flashes
	Other:		Other:		Paralysis		Other:
	Endocrine		**Skin**		Poor balance		Date of last period:
	Blood sugar problem		Bruise easily		Seizures		Age periods began:
	Use of steroids		Foot ulcers		Speech difficulties		Age of menopause:
	Over Active Thyroid		Rashes		Tremors		Are you pregnant?
	Under Active Thyroid		Sores that won't heal		Muscle wasting		# of pregnancies:
	Other:		Other:		Other:		# of live births:

Height	
Weight	

GUILFORD ORTHOPAEDIC
AND SPORTS MEDICINE CENTER

Welcome To Our Office

New Patient Information Date _____

PATIENT'S NAME (PLEASE PRINT) (FULL NAME)	NICKNAME	S.S.#	Age	SEX M F	DOB
STREET ADDRESS		CITY AND STATE			ZIP
HOME PHONE	CELL PHONE	E-MAIL			MARITAL STATUS S M W D
PATIENT'S EMPLOYER		OCCUPATION (INDICATE IF STUDENT)			BUS. PHONE EXT
EMPLOYER'S STREET ADDRESS		CITY AND STATE			ZIP
CONTACT PERSON'S NAME IN CASE OF EMERGENCY		PHONE			

SPOUSE OR PARENT'S NAME	SPOUSE OR PARENT'S NAME S.S.#	BIRTHDATE
SPOUSE OR PARENT'S EMPLOYERS	EMPLOYER'S STREET ADDRESS	BUS. PHONE EXT
SPOUSE'S STREET ADDRESS	CITY AND STATE	ZIP

NAME AND ADDRESS OF REFERRING PHYSICIAN	NAME AND ADDRESS OF PRIMARY CARE PHYSICIAN (FAMILY DR.)

PERSON RESPONSIBLE FOR PAYMENT	STREET ADDRESS, CITY, STATE	ZIP	HOME PHONE

PRIMARY INSURANCE CO. NAME	CERTIFICATE #	GROUP #
POLICYHOLDER'S NAME	POLICYHOLDER'S BIRTHDATE	
SECONDARY INSURANCE CO. NAME	CERTIFICATE #	GROUP #
SECONDARY INS. POLICYHOLDER'S NAME	SECONDARY INS. POLICYHOLDER'S BIRTHDATE	

WHAT ARE YOU SEEING THE DOCTOR FOR TODAY?	DATE OF ONSET	DESCRIPTION OF PROBLEM OR INJURY
IF THIS IS A WORK RELATED INJURY (PLEASE FILL OUT THIS SECTION)	BRIEF DESCRIPTION OF HOW ACCIDENT HAPPENED	
NAME OF EMPLOYMENT WHERE INJURY HAPPENED?	COMPLETE ADDRESS OF THAT EMPLOYER	
WAS AN AUTOMOBILE INVOLVED? ☐ YES ☐ NO STATE _____	DATE OF ACCIDENT	NAME OF ATTORNEY

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES AND COPAYMENTS REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE PERSONNEL.

VERY IMPORTANT:
PLEASE BRING INSURANCE CARDS, XRAY'S, MRI AND ANY OFFICE NOTES RELATING TO TODAY'S VISIT.

GUILFORD ORTHOPAEDIC AND SPORTS MEDICINE CENTER

Authorization to release PHI (Personal Health Information)

I hereby authorize Southeastern Orthopaedic Specialists, P.A. to release my PHI to:
(EXCLUDES PHYSICIANS & ATTORNEYS)

Name of person that information may be released to:
(i.e. spouse, parent, guardian, sibling, etc.)

Address

Patient's Name: _____ Date of Birth: _____

Address: _____

Patient's Signature: _____ Date: _____

Relationship to Patient: _____

Type of information that may be released:
(financial, medical information, information for a specific problem)

Expiration Date: _____

To revoke this authorization, it must be submitted in writing to Southeastern Orthopaedic Specialists, P.A.

There is potential for re-disclosure once this information is disclosed. SOS cannot control what the other entity does with your PHI (Personal Health Information).

GUILFORD ORTHOPAEDIC AND SPORTS MEDICINE CENTER

Guilford Orthopaedic and Sports Medicine Center
A Division of Southeastern Orthopaedic Specialists
1915 Lendew Street
Greensboro, NC 27408

Patient's Name: _____ Patients Ins: _____

Date of First Service: _____

During the past three years, have you had treatment by an Orthopaedic Surgeon in Greensboro?

Yes_____ No_____

If yes, please indicate the name of the physician and/or practice below:

_____

Name of Doctor and/or Practice Date of Service

_____ _____

Patient Signature Date

* * Please fill out and bring to your appointment. Thank you! * *

ePrescribing

Guilford Orthopaedic and Sports Medicine, A Division of Southeastern Orthopaedic Specialists are in the process of implementing ePrescribing in each of our offices.

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information-like drug interactions and your prescription history.

The benefits to you:

- Less confusion over handwritten prescriptions or unclear phone calls.
- Reduced possibility of medical errors.
- Less chance of adverse drug reactions.
- Fewer trips to drop off at the pharmacy.
- A safer, faster, easier way to get your prescriptions filled.

Patient Consent:

I agree that Guilford Orthopaedic and Sports Medicine, A Division of Southeastern Orthopaedic Specialists may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____

Patient Signature Date

_____

Printed Name

GUILFORD ORTHOPAEDIC AND SPORTS MEDICINE CENTER

Account # _____

Meaningful Use Documentation

Language:	***Race:***	***Ethnicity:***
English	American Indian	Hispanic Origin
Spanish	Asian	Non-Hispanic Origin
American Sign	African American	Type Unknown
French	Native Hawaiian	
Japanese	White	
Other	Type Unknown	

Decline: _____

******* Must update in C&S *******

Updated by: _____

GUILFORD ORTHOPAEDIC AND SPORTS MEDICINE CENTER

Southeastern Orthopaedic Specialists, PA

Financial & Insurance Policies

Murphy Wainer Orthopedics, Sports Medicine and Joint Replacement Center, Guilford Orthopaedics & Sports Medicine Center, Piedmont Orthopedics

Insurance co-pays are due at the time of your appointment and will be collected at check in. Your insurance policies may require you to make a copayment for an office visit and/or medical service, therefore payment is required on the date of service.
A $20.00 service fee will be charged if the co-pay is not paid at the time of service.

The payment collected at the time of service is an estimate based on the information available to us at the time of service. Any remaining balance after the patient's insurance processes and pays the claim is the responsibility of the patient.

No show fee of $25.00 may be charged for a missed appointment not cancelled 24hrs in advance of appointment.

Urgent Care Visits: $50.00 fee will be charged to your insurance which may or may not cover this fee. You will be responsible for any portion not covered by your insurance.

We are contracted with most major insurance carriers. **It is the patient's responsibility to verify benefits/limitations and physician participation with their carrier.** Many insurance companies require authorization for visits. If required, please obtain authorization prior to your visit. **Failure to provide authorization may result in the rescheduling and/or cancellation of your appointment.** There may be services provided that your insurance carrier will not cover. Please verify and understand your benefits. **You agree to pay any portion not covered by your insurance carrier.**

Payment requirements if you have NO insurance: A minimum deposit of $250.00 is required at check in of the initial visit. All other charges are due at time of service unless other arrangements are approved by us in advance in writing.

Patient Balances: When you receive a statement from our facility, payment is due upon receipt of the statement, unless other arrangements have been approved by the facility in writing.

A $25.00 service fee will be charged for returned checks. This charge will be applied to your account and is due immediately.

Collection Agencies: Patients who do not respond to our efforts to collect an overdue balance may be turned over to an outside collection agency. If this becomes necessary, we will attach a 25% collection fee.

All patients are required to present with a valid Photo ID at check in. A minor child (under 18) must be accompanied by a parent or legal guardian who will present their Photo ID. **NEW PATIENTS UNDER THE AGE OF 18 MUST BE ACCOMPANIED AT THE FIRST VISIT WITH PARENT OR LEGAL GUARDIAN.** At the follow up appointment the MINOR may attend themselves **WITH A WRITTEN STATEMENT PROVIDING AUTHORIZATION TO TREAT MINOR WITHOUT PARENT OR GUARDIAN. This would be required at each visit.**

Divorce: In cases of divorce or separation, the parent authorizing treatment for the child/children will be the parent responsible for charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, **it is the authorizing parent's responsibility to collect from the other parent.**

I have read this Financial Policy and understand that I am ultimately responsible for the charges incurred.

Patient Name: _____

Parent/Guarantor Signature: _____ **Date:** _____