Name:
Chart:
Date:

GUILFORD ORTHOPAEDIC AND SPORTS MEDICINE CENTER
A Division of Southeastern Orthopaedic Specialists, P.A.

Spine History of Illness - 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***

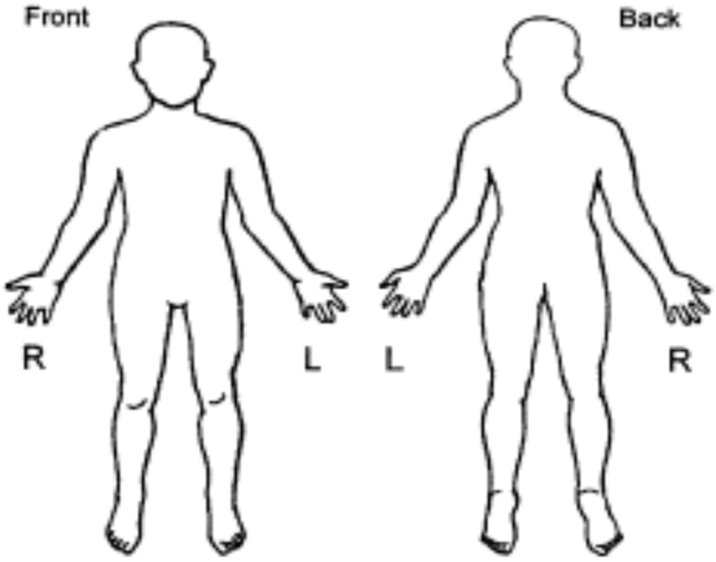
List the reason for today's visit ***(what is the problem?)***	

✓	**Symptoms:** ***(all that apply to today's visit)***	**Constant**	**Intermittent**	**Mark Your Typical Pain Intensity Here** ← ***Least Pain Worst*** →										
				0	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***
	Neck pain													
	Back pain													
	Right arm pain													
	Left arm pain													
	Right leg pain													
	Left leg pain													
	Weakness			Describe any weakness, numbness or neurologic problems here:										
	Numbness													
	Balance problems													
	Trouble using hands													

Duration of current problem	
When did you first seek medical attention?	

Pain Diagram

Using the symbols below, mark the location and type of pain on the diagram on the left. Include all affected areas.



SENSATIONS

aching	**^ ^ ^ ^ ^ ^**
sharp or stabbing	**X X X X X**
burning	**/ / / / / / / / /**
pins and needles	**- - - - - - - -**
numbness	**0 0 0 0 0 0**

Name:
Chart:
Date:

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Please answer the following questions						
	Laying Down		Sitting	Standing	Walking	Bending/Twisting
What makes your symptoms better?						
What makes your symptoms worse?						

Neurologic Functioning	Yes	No	Explain
Are you losing bowel or bladder control?			
Are you losing control of your arms or hands?			
Are you losing control of your legs or feet?			
Are you noticing problems with "fine motors skills" (i.e. buttoning buttons, opening jars, handwriting)			
Are you noticing difficulties in balance?			

Previous Treatments	Yes	No		Did treatment help? Yes	Did treatment help? No
Have you had physical therapy for your spine?			How long in therapy?		
Have you had epidural injections?			How many?		
Have you had other spinal injections?			What type?		
Have you taken anti-inflammatory medications? (Motrin, Advil, Celebrex, etc…)			List medications		
Have you taken pain medications? (Percoset, Vicodin, Darvocet, Oxycontin, etc…)			List medications		
Have you tried nerve medications? (Neurontin, Lyrica, Cymbalta, etc…)			List medications		
Have you seen a chiropractor?			Chiropractor's name		
Have you tried acupuncture?			Practitioner's name		
Have you tried traction?					
Do you use walking aids? (cane, crutches, walker, wheel chair, etc…)			What type?		

Accidents	Yes	No	
Did your problem begin with an auto accident?			Date of the accident:
Were you the vehicle driver?			
Were you wearing a seat belt?			
Are you involved in a legal accident claim?			Name of your lawyer:

Name:
Chart:
Date:

GUILFORD ORTHOPAEDIC AND SPORTS MEDICINE CENTER
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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.

Name:
Chart:
Date:

GUILFORD ORTHOPAEDIC AND SPORTS MEDICINE CENTER
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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? (circle one if so)		
Do you dip snuff or chew tobacco? (circle one if so)		
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?		
What is your occupation?		
Are you currently out of work due to your spinal condition?	if so how long?	
Who do you live with? (please include names of immediate family members)		

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	

Name:
Chart:
Date:

GUILFORD ORTHOPAEDIC AND SPORTS MEDICINE CENTER
A Division of Southeastern Orthopaedic Specialists, P.A.

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: _____

Name:
Chart:
Date:

GUILFORD ORTHOPAEDIC AND SPORTS MEDICINE CENTER
A Division of Southeastern Orthopaedic Specialists, P.A.

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

Name:
Chart:
Date:

Southeastern Orthopaedic Specialists, PA

Financial & Insurance Policies

Murphy Wainer Orthopedics, Guilford Orthopaedics and Sports Medicine Center

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 $300.00 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 a valid Government Issued 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:** _____

Name:
Chart:
Date:

GUILFORD ORTHOPAEDIC AND SPORTS MEDICINE CENTER
A Division of Southeastern Orthopaedic Specialists, P.A.

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 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.

Name:
Chart:
Date:

GUILFORD ORTHOPAEDIC AND SPORTS MEDICINE CENTER
A Division of Southeastern Orthopaedic Specialists, P.A.

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).

Name:
Chart:
Date:

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! * *