



# Orthopedic Patient Information

Please complete the following questionnaire. It is designed to assist our providers with your care and better understand your medical information. **Please answer every section.**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ SS# \_\_\_\_\_  
 Local Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Permanent Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Email: \_\_\_\_\_  
 Name of closest relative not living with you: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Relative's Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Visit Reason:

Complaint/Symptoms: \_\_\_\_\_

When did your complaint start?  Gradually  Suddenly Date: \_\_\_\_\_ Cause of Injury: \_\_\_\_\_

When is your pain the worst?  Morning  Afternoon  Evening

Have you ever been treated for this problem?  Yes  No Treating physician/hospital? \_\_\_\_\_

List treatments that have helped? \_\_\_\_\_ List treatments that have made it worse? \_\_\_\_\_

Did you have Xrays taken?  Yes  No If so, what type and where? \_\_\_\_\_

Consulting Physician: \_\_\_\_\_  MD  DO  DC

Primary Care Physician: \_\_\_\_\_  MD  DO  DC

Other Physicians: \_\_\_\_\_  MD  DO  DC

### Past Medical History: (Check all that apply)

- Diabetes  High Blood Pressure  Heart Attack  Heart Disease  Emphysema  Neurological Disease  Hepatitis   
 Seizures  Thyroid Disease  Asthma  Reflux  HIV/AIDS  Stroke/TIA  TB  
 Phlebitis  Kidney Disease  Infection  Cancer (type)  Other \_\_\_\_\_

### Past Surgical History: (Check all that apply)

- Cardiac Bypass  Angioplasty/Stents  Pacemaker  Appendectomy  Tonsillectomy  Prostate  Cataract  
 Spine (Cervical/Thoracic/Lumbar)  Carpal Tunnel  Gallbladder  Hysterectomy  
 Other \_\_\_\_\_

### Medications: See Attached List

DRUG	STRENGTH	FREQUENCY
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		

### Social History:

- Married  Single  Divorced  Widow  
 Number of Living Children: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Do you Smoke?  Yes  No  Never  
 If yes, how much do you smoke per day? \_\_\_\_\_  
 Alcohol Intake?  Never  Occasional  Mod/Heavy  
 Drug Use?  Never  Present  Past  
 Do you presently live alone?  Yes  No

Allergies:  None Known  Penicillin  Aspirin  Sulfa  Other \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Medical History, Previous Treatments

### Family History: (Check all that apply to your family)

- Diabetes    High Blood Pressure    Heart Attack    Heart Disease    Emphysema    Neurological Disease    Hepatitis    Seizures    Thyroid Disease    Asthma    Reflux    HIV/AIDS    Stroke/TIA    TB  
 Phlebitis    Kidney Disease    Infection    Cancer (type) \_\_\_\_\_    Other \_\_\_\_\_

### Review of Systems: (Check all that apply)

- Fever    Night Sweats    Weight Loss    Double Vision    Glasses    Dizziness    Deafness    Sinus Problems    Ear Ringing    Chest Pain  
 Palpitations    Shortness of Breath    Coughing Blood    Appetite Change    Diarrhea    Constipation    Abdominal Pain    Nausea  
 Vomiting    Bloody Stools    Urinary Hesitancy    Incontinence    Painful Urination    Fractures    Painful Joints    Swollen Joints    Swollen Arms/Legs  
 Weak Arms/Legs    Skin Color Changes    Rashes    Scars    Masses    Ulcers    Eczema    Hives    Hair Changes    Speech Problems  
 Difficulty Swallowing    Numbness    Tingling    Seizures    Balance Problems    Memory Problems    Coordination Problems  
 Depression    Excessive Drinking    Abnormal lymph nodes

### Previous Treatment Modalities:

Have you had any of the following for this particular complaint?	YES	NO	Would you like to try any of the following for this particular complaint?	YES	NO
Physical Therapy			Physical Therapy		
Heat or Ice			Heat or Ice		
Massage			Massage		
Ultrasound			Ultrasound		
Accupuncture			Accupuncture		

### Have you taken any of the following medication? Please list them.

Anti-Inflammatories (Aleve, Motrin, Ibuprofen, Celebrex): \_\_\_\_\_

Pain Medications: \_\_\_\_\_

Muscle Relaxers: \_\_\_\_\_

# Pain Diagram

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please complete the following questionnaire. It is designed to assess pain intensity, description, and location.  
**Please answer every section.**

Please mark on the diagram the type and location of your pain.

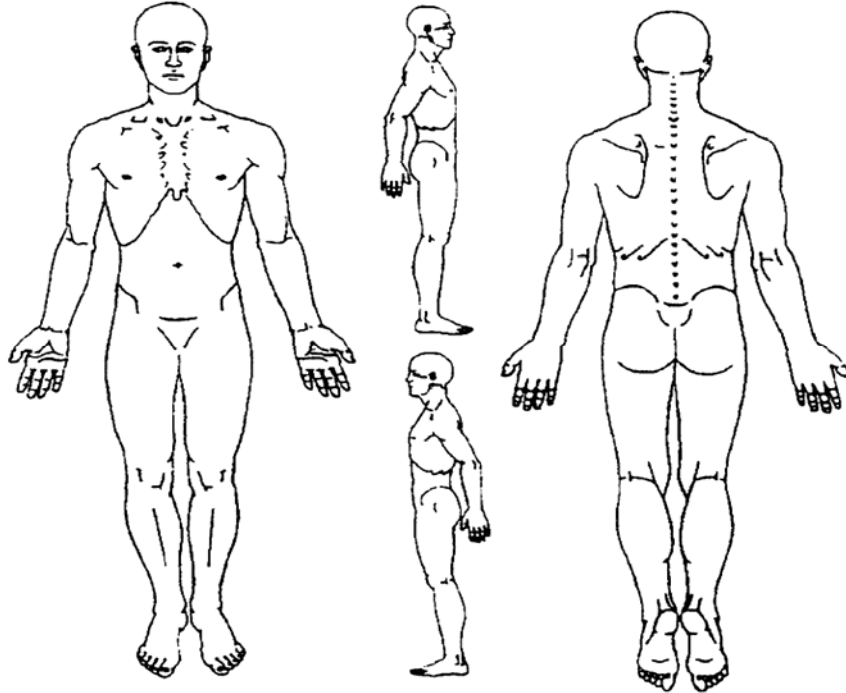
Please describe the **type of pain** or sensation you are currently experiencing by marking the pain diagram with the appropriate symbol using the descriptive words below.

**Dull/Aching Pain** XXXXX

**Sharp/Stabbing Pain** ^^^^

**Burning Pain** ::::

**Numbness/Tingling** NNNNN





## Employment & Financial Information

### Employment Information:

Patient's Employer: \_\_\_\_\_ Position: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Spouse or Parent's Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Insurance Information:

Primary Insurance Co. \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_  
 Policy Holder \_\_\_\_\_ Relationship \_\_\_\_\_ Policyholder's DOB \_\_\_\_\_  
 Insurance Claim Address \_\_\_\_\_ Policyholder's SS# \_\_\_\_\_

Secondary Insurance Co. \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_  
 Policy Holder \_\_\_\_\_ Relationship \_\_\_\_\_ Policyholder's DOB \_\_\_\_\_  
 Insurance Claim Address \_\_\_\_\_ Policyholder's SS# \_\_\_\_\_

I understand and agree that health and accidental insurance policies are an agreement between an insurance carrier and me. I authorize payment from my insurance carrier, attorney and/or other parties to Southeastern Spine Center with the understanding that all monies will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. If Southeastern Spine Center is required to attain the service of an attorney or other collection agency to collect sums which I owe, I will be required to pay for all legal fees and cost incurred by Southeastern Spine Center. I authorize Southeastern Spine Center to furnish me or my insurance company, and physicians or health care providers with my medical records or information requested regarding my past or present condition(s) or treatment(s).

### Financial Policy:

Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care. Our fees are comparable with fees of other Orthopedic Physicians in the area.

**Insurance "Usual & Customary":** Our fees are generally considered to fall within acceptable range of usual and customary by most companies and therefore are normally covered up to the maximum allowances determined by each carrier. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

**Our Policy:** Our policy requires payment at time of services. All charges are your responsibility from the date services are rendered. We will assist you in filing your own insurance claim and will provide you with an itemized charge ticket that you can simply send to your insurance carrier to expedite your reimbursement. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.

**HMO & PPO Members:** If you are a member of a HMO or PPO, in which we participate, your deductible or co-payment is required at the time of service. You are also responsible to see that we have a current authorization for each visit if your insurance carrier requires one. If you come to the office for an appointment without a valid authorization, your appointment will be rescheduled.

**Private Insurance:** Our office files insurance claims to all insurance carriers with whom we participate with (in network). Please check with our office personnel to be sure that your insurance is one that we file. All services we submit on your behalf are still your responsibility. We expect monthly payments on all services 30 days or older.

**Non-Participating Provider: (Out of Network)** If your insurance carrier does not recognize our practice, or a particular provider within our practice, your appointment will be considered an Out of Network appointment. Therefore, it would be solely your responsibility to pay Southeastern Spine Center and all of the Out of Network Yearly Deductible plus the co-pay required for services rendered. Additionally, your insurance company would reimburse you for services which you would then be required to sign the Insurance Company check over to Southeastern Spine Center for payment of your account.

**Medicare:** We are participating with Medicare. Our office submits all charges to Medicare. We also, as a courtesy, file to your supplementary insurance in most cases.

**Medicaid:** We do not accept Medicaid at Southeastern Spine Center. If you have Medicaid as a secondary insurance to your Medicare, you will be responsible for the 20% payment to Southeastern Spine Center.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Disclosures & Policies

### Financial Disclosure:

The physicians/surgeons of Southeastern Spine Center & Research Institute frequently provide educational seminars and participate in educational meetings for a number of medical device companies to educate surgeons and sales staff for these companies. Your physician/surgeon at Southeastern Spine Center & Research Institute may have participated in the development of spinal instrumentation & techniques through which he may be awarded a royalty if they are used. These implants and techniques may be used during your surgical procedures should you have surgery through Southeastern Spine Center & Research Institute. Implants & techniques may be used during your care, specifically during a surgical procedure, which are provided by a company that your physician or surgeon may have financial interest in. If you have any questions or concerns regarding this disclosure, please feel free to have a discussion with your medical provider.

### Medication Renewal Policy:

Renewing prescriptions must be done during regular office hours which are Monday through Friday, 8:00 a.m. to 4:00 p.m. To expedite the renewal of prescription medication, call your pharmacist first. They will then place a call to our office for renewal authorization. Prescription renewals are always called in at 5:00 p.m., once we complete office hours.

We realize that emergencies arise that cannot be anticipated. We must insist that our patients anticipate routine medication renewals and abide by our policy of renewals during regular office hours. Additionally, you are required to call your renewal request in to our office 48 hours in advance. Renewals called in to our office after 3:00 p.m. will be handled the next business day.

### Appointment Cancellation Policy:

Our office has implemented a policy regarding appointment cancellations. If you can not make your scheduled appointment, please notify us within 24 hours so your appointment can be cancelled or rescheduled. Failure to cancel or reschedule your appointment 24 hours in advance will result in your account being charged a fee or \$25.00. This fee is charged directly to you, as your insurance carrier does not reimburse this fee. We are sorry for any inconvenience this may cause. Thank you in advance for your cooperation.

I have thoroughly reviewed through the above listed disclosures and policies and by signing below I indicate that I understand these policies and agree to them.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### HIPAA-Summary of Privacy Practices:

The summary of our privacy practices is a condensed version of our Notice of Privacy Practices. Our complete notice is available by request at the reception desk.

**This notice describes how medial information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

We understand that your medication information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your health plan remains provide.

Here are a few examples of how we may use of disclose your information:

- For medical treatment
- To avert a serious threat to health or safety
- To obtain payment for our services
- In response to certain requesting arising out of lawsuits or other disputes
- In emergency situations
- For appointment reminders
- To inform other healthcare providers as a part of your care
- Workers' compensation

If you believe that your privacy rights have been violated, you may file a complaint with the Practice or the Secretary of the Department of Health and Human Services. To file a complaint to the practice, contact **Ellen Jomisko**. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect & copy
- The right to request restrictions
- The right to amend
- The right to a paper copy of this notice
- The right to an accounting of disclosures

For more information about these rights, please see the detailed Notice of Privacy Practices, available at our front desk.

**Due to HIPAA regulations, we will be unable to release your Private Health or Financial Information to your family, friends, or advisor without your permission.** If you wish to have such information made available to any of the above, you will need to indicate this in writing on the HIPPA Notice of Privacy Practices Acknowledgement of Receipt form. As an added security measure, you will need to give this individual(s) the last four digits of your SS# if you wish for us to speak to them by telephone. If we speak to them in person, they will need a photo ID.



## Release of Information

### Release of Information:

I authorize the following individual(s) to receive written and/or oral communications about my medical conditions, care, appointments, and the status of my account. I understand that they will need to be able to provide the last four digits of my SS# for oral communication. If they should come to pick up a prescription or to discuss my care or the status of my account, they will need to bring a photo I.D.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Mail & Telephone Messages:

Do we have your permission to?	Yes	No
Send a yearly appointment reminder or test reminders to your home?		
Call you at home?		
Call you at work?		
Leave messages on your home phone?		
Leave messages on your work phone?		
Leave messages on your home answering machine?		
Leave messages on your work answering machine?		
Share your medical and/or appointment information with another person?		
Share your medical information with another person during hospitalization?		
Share your billing information with another person? (list below)		

1. Name of Person: \_\_\_\_\_ Relationship: \_\_\_\_\_
2. Name of Person: \_\_\_\_\_ Relationship: \_\_\_\_\_
3. Name of Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Acknowledgement of Receipt:

I, \_\_\_\_\_ (Printed Patient Name), have been given a copy of the Southeastern Spine Center & Research Institute Summary Notice of Privacy Practices.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

OFFICE USE ONLY: We attempted to obtain written acknowledgement of receipts of our Notice of Privacy Practices, but acknowledgement could not be obtained because of:  Individual Refused to Sign  Communication Barrier prohibited obtaining acknowledgement  Emergency situation prevented us from obtaining acknowledgement  Other (specify) \_\_\_\_\_

## Automobile Accident

Date of Accident: \_\_\_\_\_

What complaints are due to this accident?

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What was your position in the vehicle?  Driver  Passenger

Have you ever had these complaints before?  Yes  No

Have you ever had any previous neck or back surgery?  Yes  No

Were you having any neck or back problems 6 months prior to the accident?  Yes  No

Were you wearing a seat belt?  Yes  No

Did you hit your head?  Yes  No

Did you lose consciousness?  Yes  No

Did the air bag deploy?  Yes  No

Were you burned by the air bag?  Yes  No

Did you immediately go to the hospital?  Yes  No

If not, when? \_\_\_\_\_ Name & Location? \_\_\_\_\_

How were you hit?  Front  Behind  Right Side  Left Side

What Doctors have you seen due to this accident? \_\_\_\_\_

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Did you have any imaging studies after the accident?  Yes  No

If so, what type of studies (CT, MRI, X-rays, etc)? \_\_\_\_\_

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**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_