Patient Information

(Please Fill Out Completely)

Contact Information

Full Name: Last | First | Middle | (Maiden)

Address (Street or Box) | City | State | Zip

Do you reside in a nursing home? ☐ Yes ☐ No If yes, please list the name, address and phone number below.

Name: | Address: | Phone number:

Home Phone | Cell Phone | Work Phone | Date of Birth | Social Security #

Email | Sex | Marital Status ☐ Married ☐ Single ☐ Divorced

***2012 US Federal Government Requirement:**

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ White ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Language:

Are You Employed? ☐ Yes ☐ No Please list Employer, Occupation, Position and Address:

If Student, Indicate School

Please Provide Name & Daytime Number of one of the following: ☐ Spouse ☐ Relative Other Than Parents ☐ Friend Name______________________________ Daytime Phone # ____________________

If Patient is a Minor please provide Parent or Guardian's Name: | Social Security # | Date of Birth | Parent's Phone ( )

Parent's Employer / Employer's Address | Work Phone ( )

Insurance

Do you plan to file Worker's Compensation? ☐ Yes ☐ No | If yes, who should we call to verify compensation? | Company Name: | Person to Verify: | Phone ( )

1. Name of Primary Insurance Company: | Name of Policy Holder | Birth Date of Policy Holder | Social Security # of Policy Holder | Relationship to Policy Holder

Group Number / Name | Policy Number | Is this a Medicare Advantage Plan? ☐ Yes ☐ No | Effective Date of Policy

Address | City | State | Zip

2. Name of Secondary Insurance Company: | Name of Policy Holder | Birth Date of Policy Holder | Social Security # of Policy Holder | Relationship to Policy Holder

Group Number / Name | Policy Number | Effective Date of Policy

Address | City | State | Zip

Referral

How were you referred to our office?

☐ Another physician ☐ Former patient ☐ Newspaper ☐ A friend: (Please provide name)

☐ Employer ☐ Yellow Pages ☐ Web site (name)

☐ Insurance Co. ☐ Family member ☐ Other (please specify):

Signature of Patient, Parent or Guardian: ________________________________ **Date:** __________________

New Problem Questionnaire

Last Name: _______________________ **First Name:** _________________________ **Middle Initial:** _______

Primary Physician: ____
name clinic address phone

Referring Physician: ____
name clinic address phone

Age:_________ **(circle one) Left / Right Handed** **(circle one) Female / Male**

Where is your main problem? ____

What is your main problem you want the doctor to treat today? (please check all that apply)

□ Pain □ Numbness □ Swelling □ Weakness □ Stiffness □ Unstable Joint □ Wound

Other (please describe) ____

When did your problem begin? Please give the approximate date. ______________________

Briefly describe how your problem started: _____________________________________

____

□ Job Injury □ Car Accident □ Sports Injury □ Suddenly □ Gradually

The problem is: □ constant or □ intermittent

Does your problem awaken you from sleep? □ yes □ no

The problem is: □ getting better □ getting worse □ staying the same

What worsens the problem?

□ Exercise □ Repetitive Motions □ Bending
□ Sitting □ Overhead Activities □ Stairclimbing
□ Standing □ Coughing, Sneezing, Straining □ Nothing
□ Walking □ Rest □ Other ____________________

What helps the problem?

□ Rest □ Ice □ Heat □ Medication □ Nothing □ Other: ____________________

Are any of the following activities limited because of your problem?

□ Dressing □ Bathing □ Toileting □ Feeding □ Getting up from a bed or chair

For this problem, what tests or treatments have you had and did they help?

ER ________________ Physical Therapy ________________ Nerve Test ________________
Physician ________________ X-Rays ________________ UltraSound ________________
Surgery ________________ CT Scan ________________ Chronic Pain Mgmt ________________
Injection ________________ MRI ________________ Other ________________
Medications ____

Are You Employed □ yes □ no **What is your occupation?** ______________________

Work Status

□ Regular Duty
□ Light Duty - on what date did you start light duty as a result of your new problem? ____________
□ Not working - on what date did you last work as a result of your new problem? ____________
□ Retired
□ Other ____

New Problem Questionnaire

If you are working, does your job require the following? (please check all that apply)

☐ Lifting 0 - 10 lbs	☐ Frequent Lifting	☐ Climbing	☐ Repetitive hand motions
☐ Lifting 11 - 20 lbs	☐ Frequent Sitting	☐ Extended Walking	☐ Repetitive arm motions
☐ Lifting 21 - 50lbs	☐ Frequent Kneeling	☐ Continuous Standing	
☐ Lifting over 50 lbs	☐ Frequent Bending	☐ Sitting	

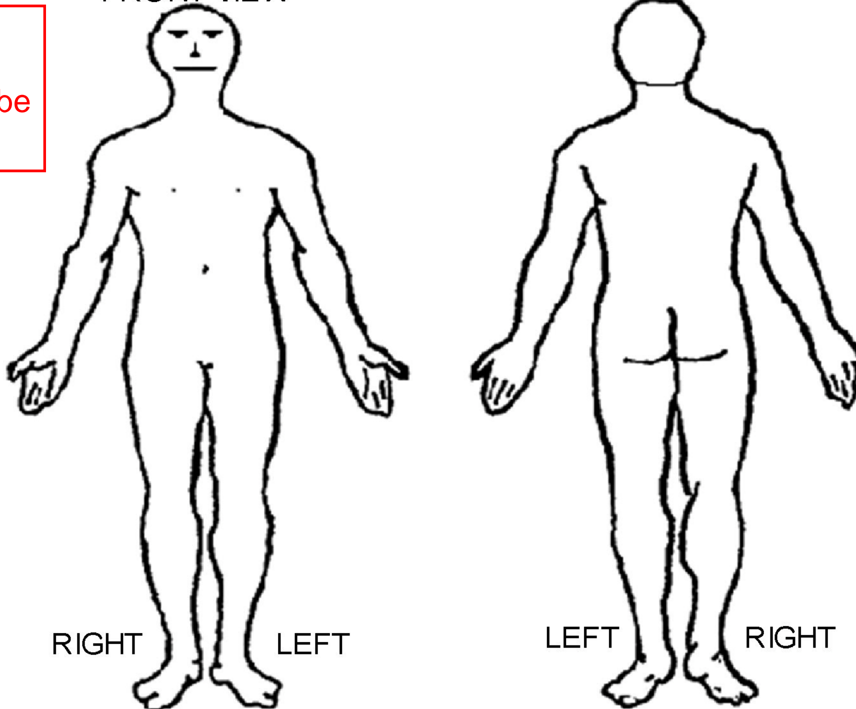
Are you planning to apply to any of the following programs because of your problem?

A. Disability ☐ yes ☐ no B. Worker's Compensation ☐ yes ☐ no

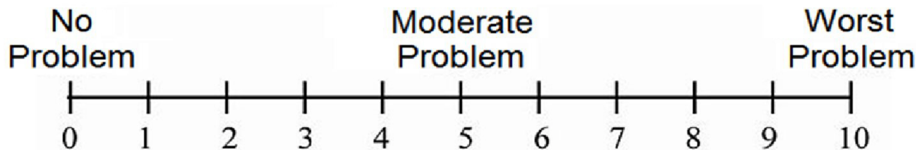
Mark where your problem is located using the symbols below. Place an "X" at the worst spot.

Aching	Numbness	Pins & Needles	Burning	Stabbing
ΔΔΔ	= = =	OOO	☐☐☐	///

Please note: This section of the form must be printed to be completed.



Please mark how bad your problem is now:



Are there any other acute problems or crises in your life now? ☐ Yes ☐ No

If yes, please explain: ____

Patient Signature: ______________________________ **Date:** ______________

Patient Medical History

Name: ______________________________ Date of Birth: ____________________

Your Gender: 1 Female 2 Male

PREVIOUS HOSPITALIZATIONS & SURGERIES - Please list **ALL** surgeries, especially all spine, arm, and leg surgeries.

Reason for Visit or Surgery, include Part of Body	Date	Hospital, Facility and/or Physician
1.		
2.		
3.		
4.		

CURRENT MEDICATIONS

Medication/Supplement/Vitamin	Dose or Strength	How Often?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

MEDICATION ALLERGIES and/or INTOLERANCES, LATEX ALLERGY ☐ None

Name of Medication to which you have a reaction	Type of Reaction
1.	
2.	
3.	
4.	

PHARMACY INFORMATION - Please list the pharmacy you primarily use

Pharmacy Name/Number (if known): ____________________

City/Town: ____________________ Phone # ____________

Street/Intersection: ____________________

Social History

Tobacco Smoke - Everyone Please Respond

☐ Never Smoker	☐ Current everyday smoker	Packs per day ________
☐ Former Smoker	☐ Current some day smoker	Number of years ________
☐ Unknown if ever smoked	☐ Smoker, current status known	

Y N

☐ ☐ Tobacco Chew, Snuff

☐ ☐ Alcohol. If yes, approximate number of drinks per week __________

☐ ☐ Street Drug Use

Do you live with anyone who can take care of you at home? ☐ Yes ☐ No

Y N Patient Medical History

- □ □ DVT, Blood Clot - 453.40
- □ □ Clotting disorder - 286.9
- □ □ Fibromyalgia - 729.1
- □ □ Old age joint disease - 719.90 (osteo arthritis) - 715.90
- □ □ Lupus or other connective tissue disease - 710.0 (lupus), 710.9 (connective tissue disease)
- □ □ Gout - 274.9
- □ □ Osteoporosis - 733.00
- □ □ Multiple bone fractures
- □ □ Blood work diagnosed joint disease (e.g. rheumatoid arthritis) - 714.0
- □ □ Chronic Pain Disorder - 338.29
- □ □ Diabetes "Sugar" - 250.00
- □ □ Low Thyroid - 244.9
- □ □ High Thyroid - 242.90
- □ □ Recurrent infections
- □ □ History of MRSA; drug resistant infection V12.04
- □ □ HIV - 042
- □ □ Peripheral Artery Disease (PAD) - 443.9
- □ □ Heart Attack, Heart Disease - 412
- □ □ High Blood Pressure - 401.9
- □ □ Irregular Heartbeat - 427.9
- □ □ Murmur - 785.2
- □ □ Asthma - 493.90
- □ □ Bronchitis - 490
- □ □ Emphysema/COPD - 492.8, 491.20
- □ □ Chronic Lung Disease - 518.89
- □ □ Kidney Disease - 593.9
- □ □ Dialysis
- □ □ GERD, Reflux, Heartburn - 530.81, 787.1
- □ □ Liver Disease - 573.9
- □ □ Hepatitis Type _______________ - A-070.1x, B-070.3x, C-070.70
- □ □ Psoriasis
- □ □ Crohn's Disease/Ulcerative Colitis - 555.9, 556.9
- □ □ Diverticulitis - 562.11
- □ □ Chronic disease type _________________________

Y N Patient Medical History

- □ □ Peripheral Neuropathy - 356.9
- □ □ Depression - 311
- □ □ Street Drug Addiction type ____________________ - 304.90
- □ □ Narcotics Addiction - 304.00
- □ □ Cancer - 239.9 type ____________________
- □ □ Stroke - 434.91
- □ □ Seizure Disorder - 345.90
- □ □ Traumatic Brain Injury - V54.52
- □ □ High Cholesterol - 272.0

Please list other disorders:

____

____

Y N Family Medical History

- □ □ Clotting Disorder
- □ □ Heart Disease
- □ □ Old Age Joint Disease (osteo arthritis)
- □ □ Connective Tissue Disease (e.g. Lupus)
- □ □ Diabetes (sugar)
- □ □ Neuropathy
- □ □ Muscle Disease: Name: ________________________
- □ □ Osteoporosis
- □ □ Cancer
- □ □ Blood Work Diagnosed Joint Disease (e.g. Rheumatoid Arthritis)

Y N Patient Review of Systems

(check all that have occurred in the past twelve months)

- □ □ Easy bleeding or bruising - 286.9
- □ □ Problems with anesthesia describe ___________________
- □ □ All over muscle pain - 729.1
- □ □ All over joint pain - 719.49
- □ □ Skin rash - 782.1
- □ □ Poor wound healing - 782.9
- □ □ Cramps legs/arms - 729.82
- □ □ Unexpected weight loss - 783.21
- □ □ Fever/chills - 780.60
- □ □ Infections in the last year type _______________________
- □ □ Fatigue - 780.79
- □ □ Headaches - 784.0
- □ □ Blurred vision - 368.8
- □ □ Difficulty swallowing - 787.20
- □ □ Chest pain - 786.50
- □ □ Palpitations - 785.1
- □ □ Fainting - 780.2
- □ □ Shortness of breath - 786.05
- □ □ Wheezing - 786.07
- □ □ Chronic cough - 786.2
- □ □ Constipation - 564.00
- □ □ Diarrhea - 787.91
- □ □ Black or bloody stools - 787.7
- □ □ Loss of control of bowels - 787.6
- □ □ Urinary frequency - 788.41
- □ □ Inability to empty bladder - 788.21
- □ □ Loss of control of bladder - 788.30
- □ □ Dizziness - 780.4
- □ □ Unsteady gait - 781.2
- □ □ Tremors - 781.0
- □ □ Cold or heat intolerance - 780.99
- □ □ Anxiety - 300.00

Patient Signature: ____ **Date:** ________________________

RALEIGH ORTHOPAEDIC CLINIC

Authorization for Release of Medical Information	
Raleigh Orthopaedic Clinic is authorized to release protected health information about the above patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.	
Person/Entity to Receive Information Check each person/entity below that you approve to receive information	**Description of Information to be Released** Check type of information below that can be provided to person/entity
Patient Contact Information: __ Voicemail Phone#(s): ___________________________ __ Email Address: ___________________________________	__ Financial __ Medical Information __ Medications
__ Spouse (Provide Name & Phone#) Name: ______________________________________ Phone Number: ________________________________	__ Financial __ Medical Information
__ Parent(s) (Provide Name & Phone#) Name: ______________________________________ Phone Number: ________________________________	__ Financial __ Medical Information
__ Others(s) (Provide Name & Phone#) Name: ______________________________________ Phone Number: ________________________________	__ Financial __ Medical Information

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forwards

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

____ Date ______________________

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

RALEIGH ORTHOPAEDIC CLINIC PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the release of medical information to my primary care or referring physician and as necessary to process insurance claims, including claims for disability benefits, insurance applications and prescriptions. I authorize transmission of medical information by fax.

Patient Name (print) ________________________________ Patient SSN# ______/_____/______

Responsible Party Signature ________________________________ Date _____ / _____ / _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I have received a copy to review of the Notice of Privacy Practices for Raleigh Orthopaedic Clinic, P.A. (ROC) and Raleigh Orthopaedic Rehabilitation Specialists (RORS).

Patient or Responsible Party
Signature ________________________________ Date _____ / _____ / _____

RX REFILLS

"I agree that Raleigh Orthopaedic Clinic may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes."

Responsible Party Signature ________________________________ Date _____ / _____ / _____

ACCEPTANCE OF FINANCIAL RESPONSIBILITY

X_______ (initial) I acknowledge full financial responsibility for services rendered by ROC/RORS, regardless of insurance coverage, Workman's Compensation coverge, and whether or not there was an accident with another party at fault. If hospitalization, surgery, or office surgery is indicated, the patient is responsible for furnishing current insurance information to the office prior to hospitalization or surgery.

X_______ (initial) In addition to charges collected at the time of service ROC may bill me for additional services provided (i.e., x-ray, MRI, medical equipment) and or balances on my account.

OUTSTANDING BALANCES

X_______ (initial) I acknowledge if my account has an outstanding balance I will not be able to make an appointment until the balance is paid in full. Any third party costs associated with collecting past due accounts will be added to the patient's account.

INSURANCE PATIENTS

X_______ (initial) ROC/RORS will file your insurance. I authorize my health insurance company to utilize the medical information as reasonably necessary for the proper administration of the health plan. I hereby assign ROC/RORS any payments of medical benefits for services rendered to myself or dependents. **Co-payments: ROC/RORS are required by your insurance to collect your co-payment. If you do not have your co-payment your appointment will be rescheduled.** I have read and understand that I am responsible for paying the annual deductible, co-payment, coinsurance and any charges for non-covered services as determined by my insurance.

SELF PAY PATIENTS

X_______ (initial) Patients will need to make a $175 deposit prior to seeing the provider, and self pay patients with a back condition will need to make a $250 deposit prior to seeing the provider.

X_______ (initial) Patients will need to pay for services rendered at each appointment whether the appointment is for a new problem or follow-up care.