

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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			
							<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced			
	*2012 US Federal Government Requirement:		Race: <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> White <input type="checkbox"/> Unknown							
			Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown							
			Language:							
	Are You Employed? Please list Employer, Occupation, Position and Address:									
	<input type="checkbox"/> Yes <input type="checkbox"/> No									
	If Student, Indicate School									
	Please Provide Name & Daytime		<input type="checkbox"/> Spouse				Daytime			
	Number of one of the following:		<input type="checkbox"/> Relative Other Than Parents							
		<input type="checkbox"/> Friend		Name _____		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		
								()		
Do you plan to file Worker's Compensation? If yes, who should we call to verify compensation? Company Name: Person to Verify: Phone										
<input type="checkbox"/> Yes <input type="checkbox"/> No										
Name of Primary Insurance Company: Name of Policy Holder Birth Date of Policy Holder Social Security # of Policy Holder Relationship to Policy Holder										
1.										
Group Number / Name		Policy Number		Is this a Medicare Advantage Plan?		Effective Date of Policy				
				<input type="checkbox"/> Yes <input type="checkbox"/> No						
Address				City		State		Zip		
Name of Secondary Insurance Company: Name of Policy Holder Birth Date of Policy Holder Social Security # of Policy Holder Relationship to Policy Holder										
2.										
Group Number / Name		Policy Number		Effective Date of Policy						
Address				City		State		Zip		
Referral	How were you referred to our office?									
	<input type="checkbox"/> Another physician		<input type="checkbox"/> Former patient		<input type="checkbox"/> Newspaper		<input type="checkbox"/> A friend: (Please provide name)			
	<input type="checkbox"/> Employer		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Web site (name)					
<input type="checkbox"/> Insurance Co.		<input type="checkbox"/> Family member		<input type="checkbox"/> 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)

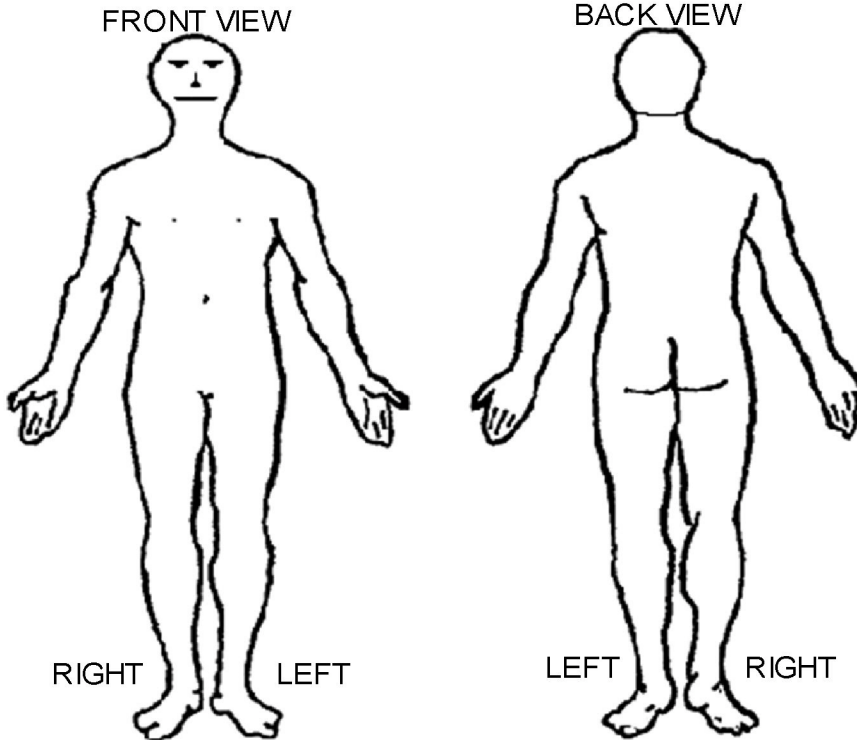
- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Lifting 0 - 10 lbs | <input type="checkbox"/> Frequent Lifting | <input type="checkbox"/> Climbing | <input type="checkbox"/> Repetitive hand motions |
| <input type="checkbox"/> Lifting 11 - 20 lbs | <input type="checkbox"/> Frequent Sitting | <input type="checkbox"/> Extended Walking | <input type="checkbox"/> Repetitive arm motions |
| <input type="checkbox"/> Lifting 21 - 50lbs | <input type="checkbox"/> Frequent Kneeling | <input type="checkbox"/> Continuous Standing | |
| <input type="checkbox"/> Lifting over 50 lbs | <input type="checkbox"/> Frequent Bending | <input type="checkbox"/> Sitting | |

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

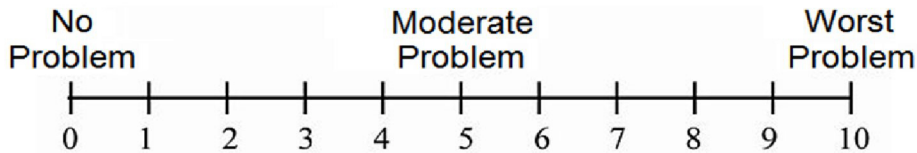
- A. Disability yes no B. Worker's Compensation yes no

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

Aching △△△	Numbness ===	Pins & Needles OOO	Burning □□□	Stabbing ///
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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

<input type="checkbox"/> Never Smoker	<input type="checkbox"/> Current everyday smoker	Packs per day _____
<input type="checkbox"/> Former Smoker	<input type="checkbox"/> Current some day smoker	Number of years _____
<input type="checkbox"/> Unknown if ever smoked	<input type="checkbox"/> 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 _____

Patient Signature: _____

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

Date: _____

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 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.

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 physician, and self pay patients with a back condition will need to make a \$250 deposit prior to seeing the physician.

OUTSTANDING BALANCES

X_____ (initial) Any patients having an outstanding balance with a collection agency 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.

Thank you for selecting Raleigh Orthopaedic Clinic for your Orthopaedic care. In order to better communicate with our patients, we are now offering email updates to enhance our communications concerning patient appointments and to provide patient education and news regarding our clinic and the Athletic Performance Center. Your email address will NOT be shared with anyone.

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)