Appointment Date: _____
Account Number: _____
Chart#: _____

ATHENS ORTHOPEDIC CLINIC, P.A.
PATIENT INFORMATION

Name: _____ Preferred(Nick) Name: _____

Address: _____City_____State_____ Zip_____

Home Phone: _____ Cell: _____ Email:_____

Date Of Birth: _____ Age: _____ Social Security #: _____ Gender: _____

Marital Status: O Single O Married O Divorced O Widowed

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Preferred Method Of Contact: O Home O Cell O Email

GUARANTOR INFORMATION:

Name: _____Relationship to Patient: _____

Guarantor Address: _____ City_____ State___ Zip_____

Gender: _____ DOB: _____ Social Security #: _____

Home #: _____Work #_____ Cell #_____

Race: O American Indian O Asian O Black O Hawaiian O White O Decline

Ethnicity: O Non-Hispanic O Hispanic O Decline

Preferred Language: O English O French O Hindi O Italian O Spanish O Other: _____ O Decline

Primary Insurance: _____ Subscriber: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____ Subscriber: _____

Policy #: _____ Group #: _____

Employer: _____ Phone: _____

Occupation: _____

Emergency Contact: _____Relationship: _____ Phone #: _____

I authorize Athens Orthopedic Clinic, P.A. to release to my insurance company, employer and/or referring physician, any information required in the course Of my examination and treatment. I also authorize any physician, hospital, or clinic to provide details of my history to Athens Orthopedic Clinic, P.A. I hereby give consent to the providers Of Athens Orthopedic Clinic, P.A., for medical treatment. I hereby assign payment directly to Athens Orthopedic Clinic, P.A. for medical benefits payable for these services. Should my claim(s) need an appeal, I authorize Athens Orthopedic Clinic, P.A. to appeal on my behalf. I understand that I am responsible for payment of services, including physician assistant and/or supply fees, rendered regardless Of insurance coverage. If a patient is a minor, I am responsible for the payment of services. I also hereby acknowledge that I have received a copy of the financial policy and agree to adhere to all policies stated in this handout. Athens Orthopedic Clinic will charge a fee of 28% of the total balance due if my account is turned over to an Outside collection agency. By signing below, I have read and understand the above.

_____ _____ _____
Patient/Responsible Signature Print Name Date

Appointment Date: _____ ATHENS ORTHOPEDIC CLINIC, P.A. NAME: _____
Account Number: _____ MEDICAL HISTORY DOB: _____ AGE: _____ GENDER: _____
Chart #: _____

Problem You Are Having Today/Complaint: _____O Right O Left O Both

How Long Have You Had This Problem? _____ When Did It Start? _____

Is This Injury A Result Of: O Work O Sports O Auto Accident O Other O No Injury

If Work, Was This Reported To Your Employer? ____ Yes ____ No

If Injury, Please State In Your Own Words What Happened:

_____

How Severe Is Your Pain On A Scale Of 0-10 With 10 Being The Most Severe? _____

Describe The Pain: O Dull O Throbbing O Sharp O Burning Timing: O All The Time O Just Sometimes

When Does The Pain/Problem Occur? (After Exercise or Night, etc.)_____

What Caused The Pain/Problem? _____

Are You Having Numbness, Swelling, Cracking, Popping, Grinding, Locking, etc. _____

What Makes The Pain/Problem Better? _____Worse? _____

Have You Seen Another Physician For This Pain/Problem Prior To Today? _____ No _____ Yes

If Yes, Who? _____

*HEIGHT:*_____*WEIGHT*: _____ Dominant Hand? O Left O Right

Have You Completed Any Therapy? ___ NO ___ Yes

Are You Pregnant? _____Yes _____No If Yes, How Far Along? _____

Are You Up TO Date On All Your Immunizations? _____Yes _____No DO You Have Osteoporosis? ___Yes ___NO

Date of Last Bone Density Test _____ Date Of Last Tetanus: _____

Are You Currently Having Or Have You Ever Had Any Of The Following:

O Atrial Fibrillation
O Asthma
O Anemia
O Arthritis
O Blood Clot/DVT
O Bronchitis
O Bleeding Disorder
O Back Trouble
O Blood Transfusion
O Chicken Pox
O Chronic Infections (MRSA)
O Cancer Type_____
O COPD
O Chest Pain/Angina
O Chronic Kidney Disease
O Congestive Heart Failure
O Diabetes
O Emphysema
O Epilepsy/ Seizure
O Glaucoma
O Gout
O Heart Attack
O Heart Disease
O Heart Murmur
O Hepatitis A B C
O High Blood Pressure/HTN
O High Cholesterol
O HIV or Aids
O Inflammatory Arthroplasty
O Kidney Infections
O Low Blood Pressure
O Lupus/SLE
O Measles
O Migraine Headaches
O Mitral Valve Prolapse
O Overactive Thyroid
O Pacemaker
O Pneumonia
O Pulmonary Embolus/PF
O Rheumatoid Arthritis
O Rheumatic Fever
O Sleep Apnea
O Stroke/CVA
O Tuberculosis
O Underactive Thyroid
O Ulcers
O Urinary Disease/ Infection
Other: _____
_____
_____

Appointment Date: _____ ATHENS ORTHOPEDIC CLINIC, P.A. NAME: _____
Account Number: _____ SURGICAL HISTORY DOB: _____ AGE: _____ GENDER: _____
Chart #: _____

Have You Ever Had an Operation: ____ No _____ Yes Please List

Date	Surgery	Body Part	Facility	Surgeon

Have You Ever Had Problems With General Anesthesia? ____No ___ Yes (Explain)

_____

Smoking Status:

O Never Smoked
O Every Day How Much Per Day _____
O Occasional How Often _____
O Former Smoker
Date Started/Ended _____

Alcohol Intake:

O Never drink
O Every Day How Much Per Day _____
O Occasional How Often _____
O Moderately How Often _____
Date Started/Ended _____

What type Of tobacco: O Cigarette O Cigar O Other

Marital Status: O Single O Married O Divorced O Widowed

DO You Exercise? ____ NO ____ Yes

How Often? O Daily O Weekly O Monthly

How Long? _____

Occupation: _____

Family History - If Yes, List Family Member, Age of Onset and If Deceased

Lungs/Breathing ___No ___Yes_____
Digestion/Heartburn ___No ___Yes_____
Bowel/Bladder/Prostate ___No ___Yes_____
Diabetes ___No ___Yes_____
Heart Problems ___No ___Yes_____
High Blood Pressure ___No ___Yes_____
Bleeding Problems/Clots/PE ___No ___Yes_____
HIV/AIDS ___No ___Yes_____
Cancer ___No ___Yes_____
Epilepsy ___No ___Yes_____

Appointment Date: _____ ATHENS ORTHOPEDIC CLINIC, P.A. NAME: _____
Account Number: _____ REVIEW OF SYSTEMS DOB: _____ AGE: _____ GENDER: _____
Chart #: _____

PLEASE INDICATE IF YOU ARE HAVING ANY OF THESE PROBLEMS NOW. PLEASE ANSWER NO OR YES TO EACH LINE.

MUSCULOSKELETAL		URINARY		PSYHCIATRIC	
Joint Pain	No Yes	Frequent Urination	No Yes	Memory Loss Or Confusion	No Yes
Joint Stiffness or Swelling	No Yes	Burning or Painful		Anxiety	No Yes
Muscle Pain or Cramps	No Yes	Urination	No Yes	Depression	No Yes
Back Pain	No Yes	Blood in Urine	No Yes		
Injury	No Yes	Incontinence or Dribbling	No Yes		

CONSTITUTIONAL SYMPTOMS		SKIN		GASTROINTESTINAL	
Recent Weight Change	No Yes	Rash Or Itching	No Yes	Nausea or Vomiting	No Yes
Fever	No Yes	Changes in Skin	No Yes	Frequent Diarrhea	No Yes
Fatigue	No Yes	Varicose Veins	No Yes	Constipation	No Yes
Headaches	No Yes	Rectal Bleeding (Blood in Stool)	No Yes	Abdominal	No Yes
Heartburn	No Yes				

EARS/NOSE/MOUTH/THROAT		NEUROLOGICAL		RESPIRATORY	
Hearing Loss or Ringing	No Yes	Light Headed Or Dizzy	No Yes	Chronic or Frequent Cough	No Yes
Nose Bleeds	No Yes	Numbness/Tingling	No Yes	Spitting Up Blood	No Yes
Bleeding Gums	No Yes	Sensations	No Yes	Shortness Of Breath	No Yes
Sore Throat or Voice Change	No Yes	Tremors	No Yes	Wheezing	No Yes

CARDIOVASCULAR		ENDOCRINE		ALLERGIES
Chest Pain	No Yes	Excessive Thirst	No Yes	List Foods/Environmental Allergies
Palpitations	No Yes	Heat or Cold Intolerance	No Yes	_____
Exercise Intolerance	No Yes	Skin Becoming Drier	No Yes	_____

HEMATOLOGIC/LYMPHATIC

Enlarged Glands No Yes Bleeding or Bruising Tendency No Yes

_____ _____
SIGNATURE OF PATIENT OR PARENT OF MINOR DATE

_____ _____
SIGNATURE OF PHYSICIAN DATE

Appointment Date: _____ ATHENS ORTHOPEDIC CLINIC, P.A. NAME: _____
Account Number: _____ MEDICATION DOB: _____ AGE: _____ GENDER: _____
Chart #: _____

Pharmacy Name, Location and Number: _____

Medication/Supplements	Dose	Frequency	Reason for Medication	Restart/ Post OP

Are You Allergic To Any Of The Following? Give Reaction if Yes

Penicillin ___No ___Yes_____

Codeine ___No ___Yes_____

Sulfa ___No ___Yes_____

Betadine/Iodine ___No ___Yes_____

Latex ___No ___Yes_____

Tape ___No ___Yes_____

Additional Allergies ___No ___Yes_____

(Include Drug, Food and Metal)_____

Patient Acknowledgement of Notice of Privacy Practices:

As required by the Privacy Standards Of the Health Insurance Portability and Accountability Act Of 1996 (HIPAA), I have had the opportunity to review and/or request a copy Of the Notice Of Privacy Practices Of Athens Orthopedic Clinic, P.A. Any questions or request for additional copies may be directed to: Athens Orthopedic Clinic, P.A., 1765 Old West Broad Street, Athens, GA 30606, Attention: Compliance Officer

I hereby authorize the following individual(s) to have access to my medical records:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

e-Rx CONSENT: e-Prescribing software sends prescriptions Over the internet to Your pharmacy safely and securely, by applying the technology used by credit card companies, e-Prescribing software helps protect Your personal information while allowing Your provider to access important data such as drug interactions and prescription history.

I agree that Athens Orthopedic Clinic may request and use my prescription medication history from other healthcare providers or pharmacy benefit payers for treatment purposes.

By signing below, I acknowledge that I have read and understand all of the above.

Signature of Patient or Guarantor: _____

Print Name: _____ Date: _____