

CARY ORTHOPAEDIC SPORTS/SPINE SPECIALISTS/PERFORMANCE PHYSICAL THERAPY

NEW PATIENT INFORMATION RECORD

DATE _____

PATIENT INFORMATION

OUR DOCTOR _____

CHART NO. _____

LAST NAME		FIRST NAME		MIDDLE INITIAL		MAIDEN NAME		Are you in a Skilled Nursing Facility?		MINOR?	
MAILING ADDRESS <input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY				CITY AND STATE			COUNTY		ZIP CODE	HOME PHONE NO. ()	
LOCAL ADDRESS				CITY AND STATE				ZIP CODE			
MARITAL STATUS		AGE	SEX	DATE OF BIRTH		RACE		ETHNICITY		PREFERRED LANGUAGE	SOCIAL SECURITY NUMBER
S	M	W	D	SEP	M	F					
REFERRING MD:			REF. DOCTOR PHONE # ()			FAMILY DOCTOR		PHARMACY NAME		PHARMACY LOCATION / INTERSECTION / ROAD	
IN CASE OF EMERGENCY PLEASE CONTACT:				RELATIONSHIP			BEST DAYTIME PHONE # ()		ALTERNATE PHONE # ()		
EMPLOYMENT STATUS <i>check one</i>		PATIENT EMPLOYER				OCCUPATION		WORK PHONE # / EXT. ()			
EMPLOYED	STUDENT	OTHER									
SPOUSE NAME			SPOUSE'S EMPLOYER			SPOUSE EMPLOYER ADDRESS					
SPOUSE WORK NUMBER ()			SPOUSE SOCIAL SECURITY NUMBER			SPOUSE DATE OF BIRTH		PATIENT EMAIL ADDRESS		PATIENT CELL NUMBER ()	

IF THE PATIENT IS A MINOR OR STUDENT, PLEASE COMPLETE BELOW:

MOTHER'S NAME		STREET ADDRESS, CITY, STATE, ZIP CODE				HOME PHONE NO. ()	
MOTHER'S EMPLOYER		SOCIAL SECURITY NUMBER			DATE OF BIRTH	BUSINESS PHONE NO. ()	
EMPLOYER'S STREET ADDRESS		CITY AND STATE				ZIP CODE	
FATHER'S NAME		STREET ADDRESS, CITY, STATE, ZIP CODE				HOME PHONE NO. ()	
FATHER'S EMPLOYER		SOCIAL SECURITY NUMBER			DATE OF BIRTH	BUSINESS PHONE NO. ()	
EMPLOYER'S STREET ADDRESS		CITY AND STATE				ZIP CODE	

BRIEFLY DESCRIBE INJURY/PAIN AND THE BODY PART WE ARE TREATING TODAY: _____		
ARE YOU BEING SEEN FOR AN INJURY? Y N MOST RECENT DATE OF INJURY OR ONSET OF PAIN ___MM___DD___YY		
ARE YOU FILING MEDICAL INSURANCE? Y N ___BCBS___MEDICARE___MEDICAID___WORKERS COMP___OTHER___		
DOES YOUR INSURANCE REQUIRE A REFERRAL/AUTHORIZATION? Y N IF NEW PROBLEM, NAME OF REFERRING DOCTOR _____		
IS SOMEONE OTHER THAN THE PATIENT OR PATIENT'S MEDICAL INSURANCE FINANCIALLY RESPONSIBLE FOR THIS INJURY? Y N		
THOUGH WE DO NOT FILE THIRD PARTY CLAIMS (I.E. AUTO ACCIDENTS, LIABILITY INJURY AND/OR LAWYERS)		
PLEASE COMPLETE THE FOLLOWING, IF APPROPRIATE:		
IS THIS A WORK RELATED INJURY? Y N	IS THE INJURY DUE TO AN AUTO ACCIDENT? Y N	_____ OTHER(LIABILITY) _____
ARE YOU FILING WORKER'S COMP? Y N	IS LEGAL ACTION PENDING? Y N	
IS LEGAL ACTION PENDING? Y N	NAME OF LAWYER _____	IS LEGAL ACTION PENDING? Y N
NAME OF LAWYER _____	TELEPHONE NO. _____	NAME OF LAWYER _____
TELEPHONE NO. _____		TELEPHONE NO. _____

I hereby authorize the designated physician to release any information acquired in the course of my treatment to my insurance company for completion of claims. In consideration of the medical services to be rendered, I agree to pay to Cary Orthopaedic & Sports Medicine Specialists the regular charges for said services. I understand that I am responsible for all charges not paid by insurance. If applicable, I also request payment of government benefits either to myself or to the party who accepts assignment. I certify that I have read the above or had it explained to me, and agree to all of its terms and as evidence of this fact sign my name below.

CONSENT FOR CARE: I, the undersigned, do hereby agree and give consent for Cary Orthopaedic Sports / Spine Specialists and/or Performance Physical Therapy to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical condition.

Patient's Signature

Date

Parent, Spouse or other Responsible Party Signature

Staff Initials

DATE _____ CHART # _____

Patient's Personal History

The following information is very important to your health. Please take the time to fully and accurately fill out this form. This form may be sent to a surgery center if surgery is ordered.

Name: Last First M.I.			Sex:	DOB:	Age:	Race:	Marital Status:
SSN:	Home#:	Cell#:		Work#:			

Emergency Contact & Phone #:

Previous Surgeries:
(Where, When, & Why)

Previous Injuries, & Hospitalizations:
(Where, When, & Why)

Other Illnesses Not Hospitalized For:

Any Allergies (drug, food, latex, adhesives, etc.):

Present Medications (please include all prescriptions and over-the-counter medications):
(Name & Dosage)

Personal Habits:

Do you use any tobacco products? Y N Every Day? _____ Some Days? _____ How Much? _____

Are you a former tobacco user? Y N

Do you drink caffeinated beverages? Y N How much per day/week? _____

Do you drink alcohol? Y N How much per day/week? _____

Additional Information:

Have you ever taken medicine for High Blood Pressure? Y N	Have you ever had an allergic reaction to latex? Y N
Had x-ray treatment to head or neck areas as a child? Y N	
Date of last EKG? _____	
Date of last chest xray? _____	
Date of last TB skin test? _____	

Review of Symptoms:

Have you had any of these symptoms within the last 6 months?

HEAD & NECK

visual disturbances Y N
 hearing or ear problems Y N
 frequent headaches Y N
 dizziness Y N
 asthma, "hay fever" Y N
 sinus troubles Y N
 frequent colds Y N
 painful swallowing Y N
 lump or swelling of neck Y N
 sore throat w/o cold Y N
 enlarged tonsils Y N
 problems with teeth Y N
 swelling of gums or jaw Y N
 tongue sore or sensitive Y N
 nosebleeds Y N

CHEST

stroke Y N
 heart attack/problems Y N
 pain in chest Y N
 chronic cough Y N
 vomited/ coughed blood Y N
 skipping or racing heart Y N

ABDOMINAL/ INTESTINAL

abdominal pain Y N

constipation Y N
 change in bowel stools Y N
 bloody/ black stools Y N
 jaundice Y N
 poor appetite Y N
 ulcers Y N
 rectal bleeding Y N

GENITO-URINARY

urinary infection Y N
 frequent urination during night Y N
 blood in urine Y N
 kidney stones Y N

BONES & JOINTS

cramps in legs Y N
 broken bones Y N
 swollen ankles Y N
 back trouble Y N
 arthritis Y N
 cyst or growth Y N

GENERAL SYMPTOMS

bleeding problems Y N
 numbness Y N
 convulsions/ seizures Y N
 unusual fatiguability Y N
 worry, depression Y N

insomnia Y N
 weight gain/ loss Y N
 nervous breakdown Y N
 fever or chills Y N
 night sweats Y N
 shortness of breath Y N

OTHER ILLNESSES

anesthesia problems Y N
 cancer Y N
 diabetes Y N
 high blood pressure Y N
 high cholesterol Y N
 other _____ Y N

*MEN ONLY

pain/ swelling in testicles Y N
 weak urine stream Y N
 prostate infection Y N

*WOMEN ONLY

hot flashes Y N
 urination when cough/ sneeze Y N
 lumps in breast Y N
 bleeding between periods Y N
 vaginal discharge Y N
 complications of pregnancy Y N

Family History:

Has anyone in your family (parents, grandparents, aunts/uncles, children) ever had...?

	Y	N	WHO?		Y	N	WHO?
Anesthesia Problems			_____	Leukemia			_____
Arthritis			_____	Mental Illness			_____
Asthma, Hay Fever, Allergy			_____	Seizures/ Epilepsy			_____
Cancer			_____	Sickle Cell Anemia			_____
Diabetes			_____	Stroke			_____
Glaucoma			_____	Thyroid Disorders			_____
Heart Attack/ Problems			_____	Tuberculosis			_____
High Blood Pressure			_____	Ulcers			_____
High Cholesterol			_____	Other:			_____
Kidney Stones			_____				_____

***WOMEN ONLY:**

of children? _____

Date of last menstrual period? _____

Last PAP smear? _____

Method of birth control? _____

Have you ever aborted or had problems with pregnancy or deliveries? _____

Completed by: Patient Other: _____ Relationship to Patient: _____

I attest that the above information is true and correct to the best of my knowledge.

Date: _____ Patient Signature: _____

Updated on: _____ Patient Signature: _____

Acknowledgement of the Use and Disclosure of Health Information for Treatment or Health Care Operations Name _____ Chart # _____

I understand that as part of the delivery of my health care, COSMS originates and maintains medical records describing my health history, symptoms, examination and test results, diagnoses, treatment and plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health care professionals who contribute to my care
- A tool for routine health care operations such as assessing quality and ensuring the continued competence of health care professionals involved in my care

- I have been provided with a Notice of Information Practices that provides a more complete description of the uses and disclosures of my health information.
- I understand that COSMS reserves the right to change this notice and their practices as needed and will make a reasonable attempt to inform me.
- I understand that I have the right to request restrictions(s) in the use or disclosure of my health information for treatment or healthcare operations and that COSMS are not required to agree to the restrictions requested.
- I understand that I may revoke this acknowledgement in writing except to the extent that COSMS has already taken action based on it.

I request the following restrictions in the use or disclosure of my health information.

Signature of Patient/Guardian/Legal Representative

Date

Relationship to Patient

Signature of Witness

Privacy Notice Effective Date/Version

For COSMS use only:

Requested Restrictions: ACCEPTED _____ DENIED _____

Signature

Title

Date

Effective March 1, 2010



FINANCIAL POLICIES AND PROCEDURES

Thank you for choosing us as your orthopaedic and physical therapy specialists. We are committed to your treatment being successful. The following is a statement of our FINANCIAL POLICIES AND OFFICE PROCEDURES which we require you to read and sign.

APPOINTMENTS

Please arrive 30 minutes prior to your appointment time to update paperwork more than six months old or 15 minutes prior to your appointment if all paperwork is up to date to review paperwork for accuracy.

CO-PAYMENTS, DEDUCTIBLES AND FEES

Co-payment, insurance deductibles and fees for service not covered by your insurance policy are collected at the time service is rendered. We accept personal checks, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS. We do not accept post dated checks. If you have surgery or fracture care, we do expect you to pay any deductible not met or co-insurance you are responsible for. Bills for surgery will not include charges for anesthesia, hospitalization or laboratory tests. These are billed separately from the facility where they are performed.

REGARDING INSURANCE

Our office will provide you with proper documentation to file your own insurance or we will file insurance for you as a courtesy provided we are supplied with the proper information. If you do have health insurance please remember that professional services are rendered and charged to you and not to the insurance company. Insurance plans we are contracted providers for, we will automatically file insurance on. Please be aware that some services provided may be non-covered services or not considered medically necessary under Medicare and/or other medical insurance programs.

If you have been involved in an automobile accident or have any pending legal action we will ask you to pay for services personally or verify subrogation through your health insurance. We do not file third party insurance and we do not wait until settlement for payment.

CONTACTING PATIENT FOR BILLING PURPOSES

In order for COSM or its representatives to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

MISSED APPOINTMENTS/CANCELLATIONS

Our policy is to charge for missed appointments or appointments canceled with less than 24 hours notice at a rate of \$25 per appt.

MEDICATION REFILLS/AFTER HOURS CONSULTATIONS

For non-emergent issues or prescriptions, we ask that you call during regular office hours, otherwise a charge will be billed directly to you.

MINOR PATIENTS

The adult parent or guardian accompanying the minor is responsible for payment of the minor patient's account regardless of who the insurance policyholder is. For unaccompanied minors, non-emergency treatment can be denied until a parent or guardian is present or we have written permission for treatment and payment of the account.

COMPLETION OF FORMS

A fee of \$25 per form will be charged as patient responsibility for completion of forms and must be paid prior to the release of the form, including the following but not limited to: Disability and FMLA.

THANK YOU FOR UNDERSTANDING THE NECESSITY OF OUR FINANCIAL POLICY AND PROCEDURES. IF YOU NEED TO MAKE SPECIAL PAYMENT ARRANGEMENTS THIS NEEDS TO BE BROUGHT TO OUR ATTENTION PRIOR TO BEING EXAMINED.

I UNDERSTAND AND AGREE TO THIS POLICY:

Signature of patient or guardian
Revised 5-2011

Date