# 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 ❑ PERMANENT ❑ TEMPORARY | CITY AND STATE | COUNTY | ZIP CODE | HOME PHONE NO. ( ) |
|---|---|---|---|---|

| LOCAL ADDRESS | CITY AND STATE | ZIP CODE |
|---|---|---|

| MARITAL STATUS S / M / W / D / SEP | AGE | SEX M / F | DATE OF BIRTH | RACE | ETHNICITY | PREFERRED LANGUAGE | SOCIAL SECURITY NUMBER |
|---|---|---|---|---|---|---|---|

| REFFERING 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 *check one* EMPLOYED / STUDENT / OTHER | PATIENT EMPLOYER | OCCUPATION | WORK PHONE # / EXT. ( ) |
|---|---|---|---|

| 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

**Name** ______________________ **Date** ______________ **Chart #** ______________

## MEDICATIONS

Please list all current medications and doses: (continue on back if needed)

| Medication | Dose | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Please list ALL medications previously tried for this problem:

______________________________________________

## SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Significant Other

Education Level: ☐ Elem / Middle School ☐ High School ☐ College ☐ Masters/Doctorate

Employment Status: ☐ Full time ☐ Part time ☐ Unemployed ☐ Disabled ☐ Modified Duty

Occupation: ______________ If disabled, for what problem? ______________

______________________________________________

Last date of employment ______________

Do you have a history of or use recreational drugs? ☐ Yes ☐ No

Do you or did you ever smoke? ☐ Yes ☐ No

If yes, how much/how long? ______________ If previous smoker, when did you stop smoking? ______________

Do you use alcohol? ☐ Yes ☐ No If so, amount/frequency ______________

## FAMILY HISTORY

| | Living | Deceased | Medical Problems |
|---|---|---|---|
| Father | ☐ | ☐ | ______________ |
| Mother | ☐ | ☐ | ______________ |
| Brothers | ☐ | ☐ | ______________ |
| Sisters | ☐ | ☐ | ______________ |

## ILLNESSES

**Please check the following conditions, illnesses, or problems you have had:**

☐ Heart: **Specify** ______________

☐ Lung: **Specify** ______________

☐ Kidney: **Specify** ______________

☐ Cancer: **Specify** ______________

☐ Stroke: **Specify** ______________

☐ Mental Illness: **Specify** ______________

☐ Hepatitis: **Specify** ______________

☐ Colon/GI: **Specify** ______________

☐ Bleeding: **Specify** ______________

☐ Blood Clot: **Specify** ______________

☐ Liver: **Specify** ______________

☐ Thyroid: **Specify** ______________

☐ Asthma ☐ Diabetes ☐ Anxiety ☐ Migraines ☐ Anemia ☐ Epilepsy

☐ HIV/AIDS ☐ High Blood Pressure ☐ High Cholesterol ☐ GERD ☐ Fibromyalgia

☐ Osteoarthritis ☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Sarcoidosis

☐ Scoliosis ☐ Sickle Cell Trait ☐ Lupus ☐ Tuberculosis

☐ Bladder problems ☐ Vascular disease ☐ Ulcers ☐ Acid Reflux

**Name** ______________________ **Date** __________ **Chart #** __________

**ALLERGIES**

Are you allergic to any medications or food that you know of? ☐ Yes ☐ No

| **Drug Allergy** | **Reaction** |
| --- | --- |
| | |
| | |
| | |
| | |

Are you allergic to iodine or contrast dye? ☐ Yes Reaction: ______________ ☐ No

Are you allergic to latex? ☐ Yes Reaction: ______________ ☐ No

**SURGICAL HISTORY**

**Please list any surgeries you have had on the lines provided:**

____________________

____________________

____________________

____________________

Neck Surgery: Type ______________ Date: ________ Performing Physician ______________

Back Surgery: Type ______________ Date: ________ Performing Physician ______________

**PROCEDURES/TESTS**

**Which of the following has been done? If you have had any of these procedures, please bring in the imaging with you.**

| | When | Where |
| --- | --- | --- |
| X-RAYS | | |
| CAT scan | | |
| MRI | | |
| Mylogram | | |
| Bone Density Scan | | |
| EMG/NCS | | |
| Spinal Injections | | |
| Physical therapy | | |
| Chiropractic | | |
| Discogram | | |

Name ______________________________ Date ______________ Chart # ____________

## REVIEW OF SYSTEMS

**General**
- ☐ Fever
- ☐ Chills
- ☐ Weight loss > 10 lbs.
- ☐ Weight gain > 10 lbs.
- ☐ Generally feeling ill
- ☐ Extreme Fatigue
- ☐ Excessive Thirst
- ☐ Cannot relax

**Heart**
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Racing heartbeat/rhythm

**Genito-Urinary**
- ☐ Blood in urine
- ☐ Burning with urinations
- ☐ Frequent urination
- ☐ Difficulty controlling urine
- ☐ Loss of urine control with coughing or sneezing
- ☐ Change in menstrual cycle
- ☐ Unusual vaginal bleeding

**Vision**
- ☐ Blurred Vision
- ☐ Red itchy eyes

**Lungs**
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Wheezing
- ☐ Pleurisy

**Musculoskeletal**
- ☐ Joint Cramping
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Warm red joints

**Psychological**
- ☐ Unusual Stress
- ☐ Anxiety
- ☐ Depression

**Neurologic**
- ☐ Headaches
- ☐ Confusion
- ☐ Seizures / Tremors
- ☐ Poor balance
- ☐ Trouble starting arm or leg motion
- ☐ Trouble walking

**ENT**
- ☐ Difficulty Swallowing
- ☐ Difficulty Hearing
- ☐ Sinus Trouble
- ☐ Sore Throat

**Gastrointestinal**
- ☐ Acid Reflux
- ☐ Loss of Appetite
- ☐ Trouble with bowel habits
- ☐ Black tarry stools
- ☐ Ulcer pain
- ☐ Nausea / Vomiting
- ☐ Diarrhea
- ☐ Constipation

**Skin**
- ☐ New skin sores
- ☐ New skin lumps
- ☐ Skin discoloration
- ☐ Easy bruising / bleeding
- ☐ Swollen lymph nodes

**CARY ORTHOPAEDIC**
*sports medicine specialists*
*spine specialists*

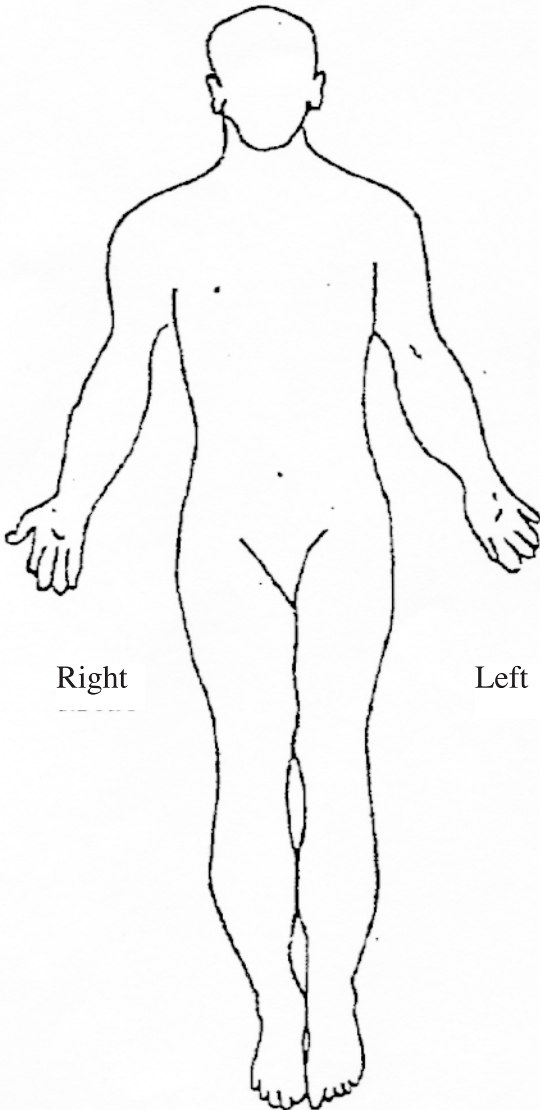
**Pain Diagram**

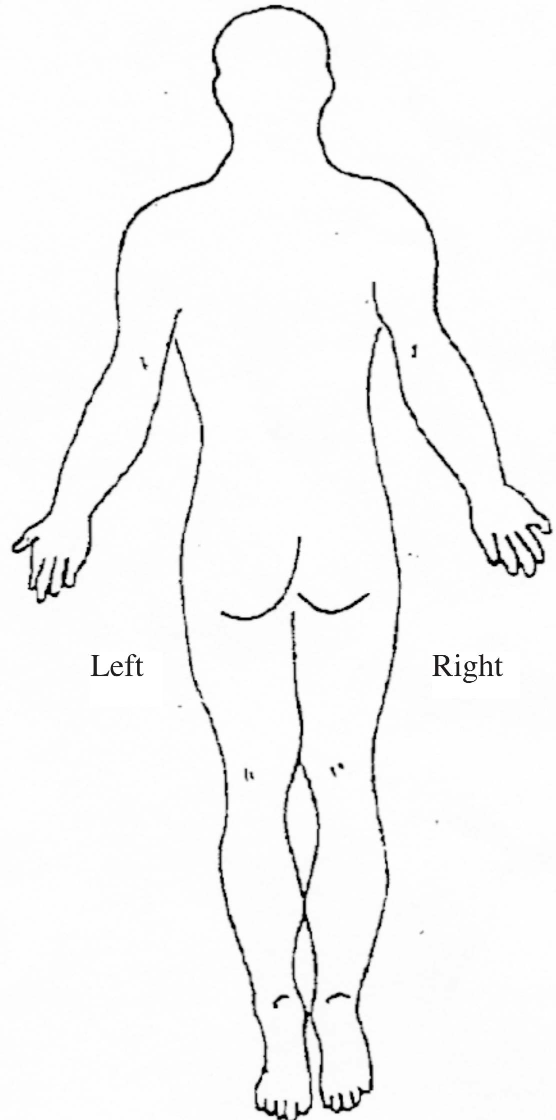
| DATE |
|---|
| |

Patient Name:______________________________________

| | | | | | |
|---|---|---|---|---|---|
| - - -<br>- - - | Pins and<br>Needles | z z z<br>z z z | Stabbing | B B B<br>B B B | Burning |
| x x x<br>x x x | Numbness | /// /// ///<br>/// /// /// | Aching and<br>Cramping | O O O<br>O O O | Other<br>Sensations |

Mark the location(s) of your pain on the body outlines using the symbols




Please circle where your pain is TODAY

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain ever)

Please circle where your pain has been on average over the LAST WEEK

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain ever)

CARY ORTHOPAEDIC
sports medicine specialists
spine specialists

PERFORMANCE
physical therapy

**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

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- 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 April 14, 2003

# 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 Date

Revised 5-2011