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

LOCAL ADDRESS	CITY AND STATE	ZIP CODE

HOME PHONE #	PATIENT CELL #	PATIENT E-MAIL ADDRESS

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

EMPLOYMENT STATUS *check one* EMPLOYED STUDENT OTHER	PATIENT EMPLOYER	OCCUPATION	WORK PHONE # / EXT.

REFERRING MD:	REFERRING DOCTOR PHONE #	FAMILY DOCTOR	PHARMACY NAME	PHARMACY LOCATION / INTERSECTION / ROAD

IN CASE OF EMERGENCY PLEASE CONTACT:	RELATIONSHIP	EMERGENCY CONTACT'S BEST DAYTIME PHONE # & AN ALTERNATE PHONE #

SPOUSE NAME	SPOUSE WORK NUMBER	SPOUSE SOCIAL SECURITY NUMBER	SPOUSE DATE OF BIRTH

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

1. Briefly describe injury/pain: _____

   Right Side _____ Left Side _____ Bilateral (both sides) _____

2. Is this problem due to an injury? **YES** or NO

2a. If **NO**, what is the date when pain/problem started? MO/DAY/YEAR _____ **SKIP 2b, GO TO 3**

2b. If **YES**, what was the date of injury? MO/DAY/YEAR _____

i. Where did injury occur (football field, grocery store, home, work, etc) _____

ii. What were you doing when injury occurred (walking, slipping, falling (flat or steps), playing, etc): _____

_____ if MVA, were you Driver _____ or Passenger _____

iii. Was injury due to military activity _____, civilian working for pay _____, off duty military _____, volunteer _____,

leisure activity _____, student _____, student athlete _____, other _____

iiii. Is WC, AUTO insurance or Liability Insurance financially responsible to pay for this injury? **YES** or NO

If **YES**, please give details (names, phone #, etc) _____

Please note, we do not file third party claims (auto insurance, liability insurance and/or to your attorney), Please discuss with your check-in person.

3. 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

CARY ORTHOPAEDIC
sports medicine specialists

PERFORMANCE
physical therapy

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 _____

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

- 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 agree that COSM can EMAIL me unsecured HIPAA protected information to the email address on patient information sheet and/or to the following email address**_____

❑ I request the following **RESTRICTIONS** in the use or disclosure of my health information.

_____

_____

❑ I request that the following person(s) have access to my medical and financial records.

_____

_____

X _____

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

CARY ORTHOPAEDIC
sports medicine specialists
spine specialists

E 3 / NP PAPERWORK

Patient Name: _____ Account Number: _____ Date: _____

Age: _____ Height: _____ Weight: _____ Occupation: _____ HowLong? _____

❑ Right Handed ❑ Left Handed

What is the main reason for your visit today? _____

When did your symptoms begin? _____

How did your symptoms occur? ❑ Gradually ❑ Suddenly

Are your symptoms due to a work injury? ❑ Yes ❑ No

Are your symptoms due to an auto accident? ❑ Yes ❑ No

If you were injured please explain how: _____

Have your symptoms changed since they began? ❑ Yes ❑ No

If so, how? _____

Have you ever had any similar symptoms? ❑ Yes ❑ No

Check the following words which best describe your symptoms:

❑ Sharp ❑ Numbness ❑ Dull ❑ Tingling ❑ Electrical

❑ Burning ❑ Spasms ❑ Aching ❑ Skin Sensitivity

❑ Weakness ❑ Changes to your bowel/bladder pattern, if yes, please specify:

❑ Incontinence ❑ Erectile Dysfunction

_____

The following factors make the pain **BETTER**:

❑ Sitting ❑ Standing ❑ Lying Down ❑ Flexing Forward

❑ Extending Backwards ❑ Walking ❑ Reaching

❑ Overhead Activity ❑ Neck Motion

The following factors make the pain **WORSE**:

❑ Sitting ❑ Standing ❑ Lying Down ❑ Flexing Forward

❑ Extending Backwards ❑ Walking ❑ Reaching

❑ Overhead Activity ❑ Neck Motion

The symptoms are mainly in the: ❑ Back ❑ Neck ❑ Legs ❑ Arms

Please rate your pain in the following body parts on a scale of 0-10 with 10 being the worse pain:

Back _____ Neck _____ Legs _____ Arms _____

When is your pain worse? ❑ Day ❑ Night ❑ No Difference

How many hours do you sleep each night? _____

MEDICATIONS

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

Medication	Dose	Reason

ALLERGIES

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

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

Are you allergic to shellfish or seafood? ☐ Yes Reaction: _____ ☐ No

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

SOCIAL HISTORY

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? _____

_____

Marital Status _____ Who is at home with you? _____

Last date of employment _____

What is your caffine intake each day: _____

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

	Age	Living	Deceased	Medical Problems
Father	_____	☐	☐	_____
Mother	_____	☐	☐	_____

Siblings ☐ Yes ☐ No How many? _____ Ages _____

ILLNESSES

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

☐ Heart: **Specify** _____ ☐ Hepatitis: **Specify** _____

☐ Lung: **Specify** _____ ☐ Colon/GI: **Specify** _____

☐ Kidney: **Specify** _____ ☐ Bleeding: **Specify** _____

☐ Cancer: **Specify** _____ ☐ Blood Clot: **Specify** _____

☐ Stroke: **Specify** _____ ☐ Liver: **Specify** _____

☐ Mental Illness: **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	☐ Multiple Sclerosis	☐ Nerve Disorder

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	_____	_____
Myelogram	_____	_____
Bone Density Scan	_____	_____
EMG/NCS	_____	_____
Spinal Injections	_____	_____
Physical therapy	_____	_____
Chiropractic	_____	_____
Discogram	_____	_____
Spinal Surgery	_____	_____

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 Pain
- ☐ Racing Heart

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
- ☐ Easily Confusion
- ☐ Seizures / Tremors
- ☐ Poor balance or walking
- ☐ Trouble starting arm or leg motion

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

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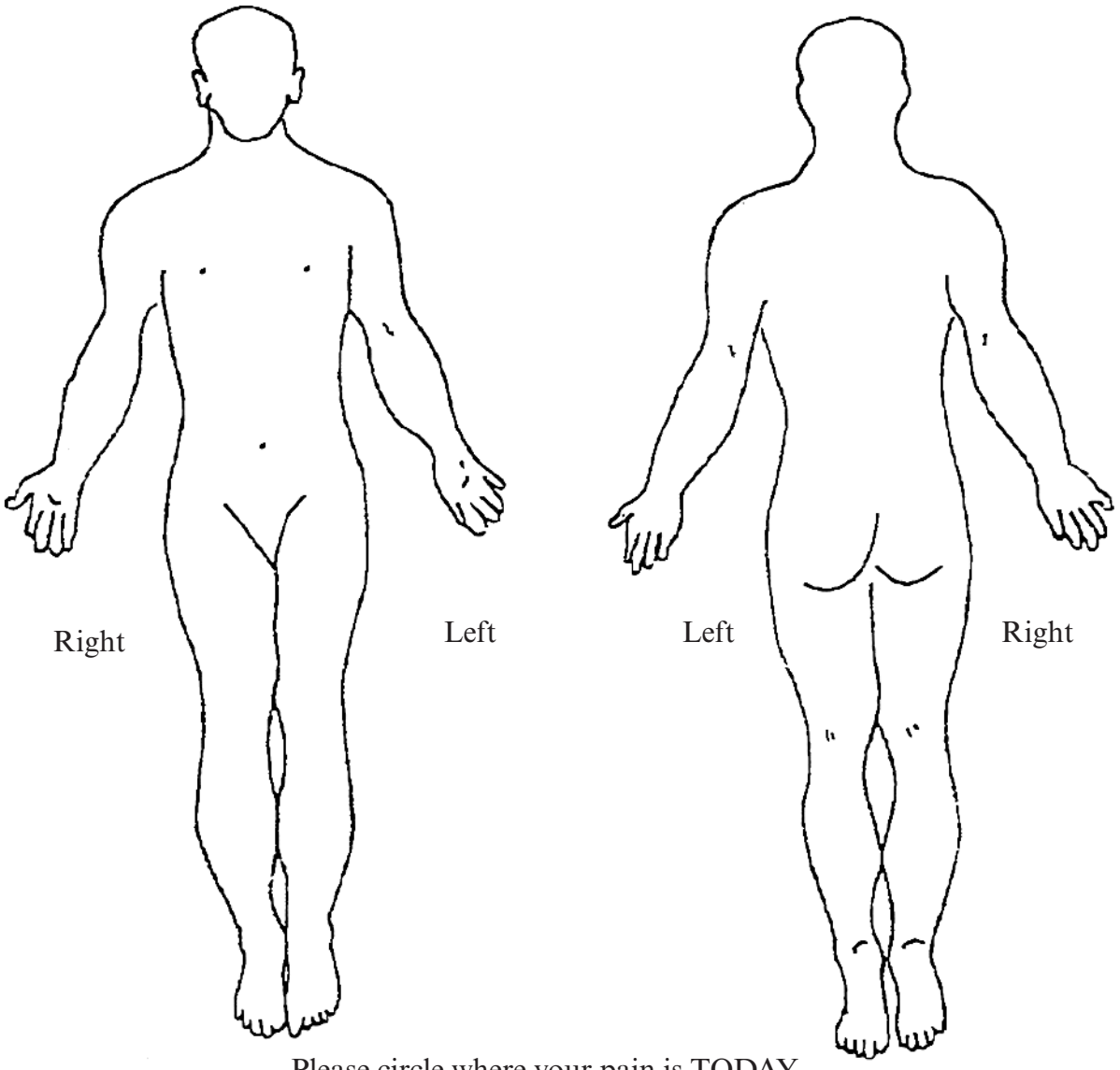
Pain Diagram

DATE

Patient Name:_____

- - - Pins and - - - Needles	z z z Stabbing z z z	B B B Burning B B B
x x x Numbness x x x	/// /// /// Aching and /// /// /// Cramping	O O O Other O O O 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)