CARY ORTHOPAEDIC SPORTS/SPINE SPECIALISTS AND PERFORMANCE PHYSICAL THERAPY

PATIENT INFORMATION RECORD

OUR DOCTOR _____ **DATE** _____ **CHART NO.** _____

LAST NAME	FIRST NAME	MIDDLE INITIAL	MAIDEN NAME	ARE YOU A MINOR? ☐ ARE YOU IN A NURSING FACILITY? ☐

MAILING ADDRESS	CITY	STATE	ZIP CODE

LOCAL ADDRESS ☐SAME AS MAILING ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE #	CELL PHONE #	PREFERRED CONTACT METHOD ☐TEXT ☐HOME ☐CELL ☐EMAIL	EMAIL ADDRESS

MARITAL STATUS (S M W D SEP)	AGE	SEX (M F)	DATE OF BIRTH	RACE	ETHNICITY	PREFERRED LANGUAGE

EMPLOYMENT STATUS (circle one) EMPLOYED / STUDENT / OTHER	PATIENT EMPLOYER	WORK PHONE #	SOCIAL SECURITY NUMBER

FAMILY DOCTOR	FAMILY DOCTOR PHONE #	PHARMACY NAME	PHARMACY LOCATION/INTERSECTION

EMERGENCY CONTACT NAME	RELATIONSHIP	EMERGENCY CONTACT'S BEST PHONE #

SPOUSE NAME	SPOUSE BEST PHONE #	SPOUSE DATE OF BIRTH

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

MOTHER'S NAME	DATE OF BIRTH	BEST PHONE #

STREET ADDRESS, CITY, STATE, ZIP CODE	SOCIAL SECURITY #

FATHER'S NAME	DATE OF BIRTH	BEST PHONE #

STREET ADDRESS, CITY, STATE, ZIP CODE	SOCIAL SECURITY #

1. List Body Part(s)/ Briefly describe discomfort _____

Right ____ Left ____ Bilateral (both) ____

2. On a scale of 1-10 what is your pain right now?_____

3. What date did this problem/pain begin? (Approximately) MO/DAY/YEAR _____

4. Is this problem due to an injury? **YES** or NO **If yes go to 4a.**

4a. Where did the injury occur? (football field, grocery store, home, etc) _____

4b. What were you doing when the injury occurred? (walking, falling, playing) _____

4c. Was the injury due to the following? military activity__ volunteer __ student __ student athlete __ leisure activity __

5. Will you be filing though Workers Compensation, AUTO insurance, or Liability Insurance? **YES** or NO

5a. If **YES,** please give details (names, phone #'s, claim #'s, etc) _____

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 I agree to all of its terms and as evident of this fact sign my name below.

CONSENT FOR CARE: I, the undersigned, do hereby agree and give consent for Cary Orthopaedic Sports and 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 Name)

Signature of Patient/Guardian/Legal Representative Date Staff Initials

Cary Orthopaedics

PERFORMANCE physical therapy

Acknowledgement of the Use and Disclosure of Health Information for Treatment or Health Care Operations

Name _____ **Chart #** _____

This HIPAA form is designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers.

I understand that as part of the delivery of my health care, COSMS (Cary Orthopaedic Sports Medicine Specialists) 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 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 COSMS can EMAIL me secured HIPPA protected information to my email address.**

☐ I agree that COSMS may leave a message on my voicemail whaen unable to reach me on my home or cell phone.

☐ I request that the following person(s) have **ACCESS** to my medical and financial records. (i.e. talk to the doctor on my behalf, pick up prescriptions/ medical records, make or change appointments)

_____

_____

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

_____

For COSMS use

Requested Restrictions: ACCEPTED _____ DENIED_____

_____

Signature of Patient/Guardian/Legal Representative Date Witness Initials

FINANCIAL POLICIES AND PROCEDURES

Thank you for choosing Cary Orthopaedics and Performance Physical Therapy as your orthopaedic and physical therapy providers. We are committed to the successful treatment and outcomes for all of our patients. The following is a statement of our financial policies and procedures which we require you to read and sign.

APPOINTMENTS

When scheduling an appointment, our patient services coordinators will ask you to arrive 30 minutes prior to your appointment time to update any paperwork that is more than six months old, or 15 minutes prior to your appointment time if all paperwork is up to date.

CO-PAYMENTS, DEDUCTIBLES, CO-INSURANCE, AND FEES

Co-payment, deductibles, co-insurance, and fees for services not covered by your insurance policy are due and will be collected at the time services are rendered. We accept personal checks, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, and CARECREDIT. We do NOT accept postdated checks. If you are having surgery or are scheduled for any in office procedure, your insurance benefits will be verified prior to the procedure, and an estimate of the cost will be provided to you. This estimate does not include charges for anesthesia, facility, facility related charges for DME or hardware, or rehabilitation services; you will be billed separately for these services by the facility or rendering provider. You will be expected to pay any co-payments, deducible, and/or co-insurance responsibility prior to your procedure.

REGARDING INSURANCE

Per our in-network contracts, we will automatically file your insurance for services rendered. Should you choose, our office will provide you with proper documentation to file your insurance on your own. Please remember that you will be responsible for any co-pay, deductible and/or co-insurance that your insurance company deems your responsibility.
NOTE: Some services provided may be deemed “non-covered services” or “not considered medically necessary” by your insurance carrier. You may be responsible for paying for these services. We will not file out-of-network insurance that requires authorization.

We **DO NOT** file third party insurance and, we do not wait until settlement for payment.

INSURANCES REQUIRING AUTHORIZATION OR REFERRAL (HMO’s, WC, etc)

Many insurance companies require referrals or authorizations for services rendered by an in-network provider. It is the responsibility of the patient to ensure that all required referrals and authorizations are in place prior to their appointment being scheduled. Any services denied by your insurance company for lack of referral or authorization will be billed to and deemed the responsibility of the patient.

PAST DUE AND COLLECTION ACCOUNTS

Cary Orthopaedics and Performance Physical Therapy require that all accounts with **Past Due or Collection** balances be paid in full prior to scheduling any appointment, including surgical or in office procedures. Any fees associated with checks returned by the bank for insufficient funds will be charged to the patient and are required to be paid before any appointment including, surgical or in office procedures, are scheduled.

MISSED APPOINTMENTS/CANCELLATIONS

Our policy is to charge for missed appointments or appointments canceled with less than 24 hours notice at a rate specific to the appointment type. This charge is not billable to your insurance company and will be the patient’s responsibility to pay.

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 will be denied until the 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 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. This charge is not billable to your insurance company and will be the patient’s responsibility to pay.

I have read and understand Cary Orthopaedics and Performance Physical Therapy’s financial policies and procedures. I understand that I am responsible for paying the deductible, co-payment, co-insurance, and any charges for non-covered services as determined by my insurance carrier. In addition to charges collected at the time of service, COSMS may bill me for additional serviced provided (ie, x-ray, MRI, medical equipment), and /or balance remaining on my account after my insurance carrier has responded to the claims.

Signature of Patient/Guardian/Legal Representative Date

CARY ORTHOPAEDIC
spine specialists

Dr. Sameer Mathur
New Patient Paperwork

Patient Name:_____ Acct.#: _____ Date:_____ Age:_____

Height:_____ Weight:_____ Occupation:_____ How Long?_____

Date of last Flu Vaccine_____ Date of last Pneumonia Vaccine_____

MEDICAL HISTORY: What is your chief complaint? (Please describe your problem.)_____

_____

_____

When did your symptoms begin?_____

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: _____

_____

Do you have neck pain? ☐ Yes ☐ No

☐ Loss of neck motion ☐ Difficulty holding up the neck ☐ Overhead activity ☐ Headaches

☐ Pain is worse with bending the neck forward. ☐ Pain is worse with bending the neck backwards.

Do you have arm pain? ☐ Yes ☐ No

Which arm is painful? ☐ Left Arm ☐ Right Arm

Do you have weakness in the arms? ☐ Yes ☐ No

Do you have numbness and tingling? ☐ Yes ☐ No

Do you have difficulty with holding objects due to weakness? ☐ Yes ☐ No

Loss of fine motor activities (buttoning your shirts, zipping up pants or coats, handwriting changes) ☐ Yes ☐ No

Do you have poor balance when walking? ☐ Yes ☐ No

Does placing your arm above your head help with your arm pain? ☐ Yes ☐ No

Have you been diagnosed with any of the following:

☐ Carpal Tunnel Syndrome ☐ Ulnar Nerve Compression ☐ Shoulder Problem

Out of 100% what percentage is your neck pain _____% and what percentage is your arm pain _____%?

Do you have pain in the thoracic spine (area below the neck where the ribs are located)? ☐ Yes ☐ No

Does the pain radiate to the ribs? ☐ Yes ☐ No

Does the pain radiate to the neck or lower back? ☐ Yes ☐ No

Have you had kidney stones in the past? ☐ Yes ☐ No

Have you been diagnosed with Osteoporosis or Osteopenia? ☐ Yes ☐ No

Have you been told you have a broken rib? ☐ Yes ☐ No

Do you have low back pain? ☐ Yes ☐ No

Is the pain worse with sitting? ☐ Yes ☐ No

Is the pain worse with standing and/or walking? ☐ Yes ☐ No

Does your pain worsen when changing positions (ie going from a sitting to standing position)? ☐ Yes ☐ No

Pain is worse with leaning forward (flexion)? ☐ Yes ☐ No

Pain is worse with leaning backwards (extension)? ☐ Yes ☐ No

Do you have leg pain? ☐ Yes ☐ No

Which leg is painful? ☐ Left Leg ☐ Right Leg

Do you have weakness in the leg? ☐ Yes ☐ No

Do you have numbness and tingling? ☐ Yes ☐ No

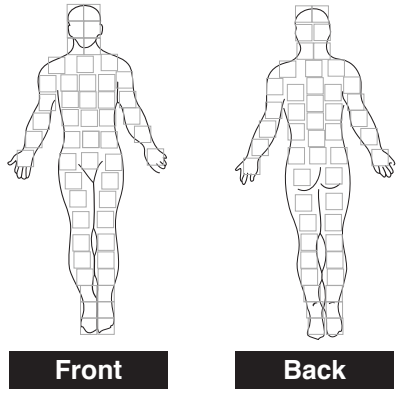
Do you have a shooting pain when you straighten your leg? ☐ Yes ☐ No

Which of the following makes your leg pain worse? ☐ Sitting ☐ Standing ☐ Walking

Do you use an assistive device to ambulate? ☐ Cane ☐ Walker ☐ Wheelchair

Out of 100% what percentage is your back pain _____% and what percentage is your leg pain _____%?

On the diagram, please mark where your pain is today.



Please rate where your pain is TODAY.

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

Please rate 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)

PROCEDURES/TEST

Which of the following studies have been performed related to your chief complaint? If you have had any of these imaging studies, please bring the imaging CD, radiographs, and reports with you.

	Date	Location
X-rays		
CT Scans		
MRI		
Myelogram		
Bone Density Scan		
EMG/NCS		

	Date	Number of Visits Attended	Where	Body Part Treated	Helpful
Physical Therapy					(Yes/No)
Chiropractic Care					(Yes/No)

	Date	Location of Injection	Physician Performing Procedure	Helpful
Spinal Injections				(Yes/No)
Spinal Injections				(Yes/No)
Spinal Injections				(Yes/No)

PAST MEDICAL HISTORY

Do you have loss of your bowel and bladder function? ☐ Yes ☐ No

If yes when did the problem start? _____

Please check all major illness and conditions you have ever been diagnosed with.

☐ Acid Reflux	☐ Fibromyalgia	☐ Liver Disease	☐ Rheumatoid Arthritis
☐ Anemia	☐ GERD	☐ Lung Disease	☐ Sacroidosis
☐ Anesthesia Complications	☐ GI Bleeding	☐ Lupus	☐ Scoliosis
☐ Aneurysm	☐ Gout	☐ Migraines/Headaches	☐ Seizures
☐ Bladder Problems	☐ Heart Attack	☐ MRSA	☐ Sickle Cell Trait
☐ Bleeding Disorder	☐ Heart Failure	☐ MSSA	☐ Sleep Apena
☐ Blood Clots/DVT	☐ Heart Murmur	☐ Multiple Sclerosis	☐ Staph Infection
☐ Cancer (Type:_____)	☐ Hepatitis B	☐ Nerve Disorder	☐ Stents
☐ Cirrhosis	☐ Hepatitis C	☐ Osteoarthitis	☐ Stroke
☐ COPD	☐ High Blood Pressure	☐ Osteopenia	☐ Thyroid Disease
☐ Coronary Artery Disease	☐ High Cholesterol	☐ Pacemaker/Defibrillator	☐ Tuberculosis
☐ Diabetes	☐ HIV/AIDS	☐ Psoriasis	☐ Ulcers (GI)
☐ Emphysema	☐ Irregular Heart Beat	☐ Pulmonary Embolism	☐ Vascular Disease
☐ Epilepsy	☐ Kidney Disease	☐ Pulmonary Hypertension	☐ Other:_____

SURGICAL HISTORY

Please list any surgeries including spine surgeries you have undergone:

Type of Surgery (ie Neck/Back)	Date	Performing Physician	Helpful
			(Yes/No)
			(Yes/No)
			(Yes/No)
			(Yes/No)
			(Yes/No)

SOCIAL HISTORY

☐ Never Smoker

☐ Former Smoker Date when you stopped smoking: _____

☐ Current Smoker Packs Per Day: _____ Number of Years: _____

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

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

Do you now or have a history of substance abuse? ☐ Yes ☐ No

FAMILY HISTORY

Condition	Relationship to Patient	Condition	Relationship to Patient
Alzheimer's Disease		Osteoarthritis	
Cancer (Type:_____)		Rheumatoid Arthritis	
Diabetes		Scoliosis	
Heart Disease		Seizures	
Lung Disease		Stroke	
Multiple Sclerosis		Tuberculosis	
Parkinson's Disease		Other:_____	

REVIEW OF SYSTEMS

General	Skin	Eyes	Respiratory	Cardiovascular
☐ Fever	☐ Rash	☐ Blurry Vision	☐ Cough	☐ Chest Pains
☐ Chills	☐ Itching	☐ Blindness	☐ Wheezing	☐ Palpations
☐ Weight Change	☐ Dryness	☐ Eye Pain/Discharge	☐ Coughing up Blood	☐ Fainting
☐ Sweats	☐ Suspicious Sores/ Lesions/Lumps	☐ Sensitivity to Light	☐ Shortness of Breath	☐ Ankle Swelling
☐ Generally Feeling Ill			☐ Asthma	☐ Breathing Difficulty
☐ Extreme Fatigue				
☐ Sleep Disturbance				

Gastrointestinal	Genitourinary	Pyschological	Neurologic	Musculoskeletal
☐ Constipation/Diarrhea	☐ Frequent Urination	☐ Unusual Stress	☐ Seizures/Tremors	☐ Joint Pain Swelling
☐ Indigestion	☐ Painful Urination	☐ Anxiety	☐ Migraines/Headaches	☐ Muscle Pain/Weakness
☐ Nausea/Vomiting	☐ Blood in Urine	☐ Depression	☐ Memory Loss	☐ Trauma/Fracture
☐ Change in Bowel Habits	☐ Bladder Control		☐ Poor Balance When Walking	☐ Joint Stiffness
	☐ Pelvic Pain	**ENT**		
☐ Abdominal Pain		☐ Difficulty Swallowing	☐ Difficult Arm/Leg Movement	
☐ Bloody Stool		☐ Difficulty Hearing		
☐ Jaundice		☐ Sinus Trouble		
		☐ Sore Throat		

CURRENT MEDICATIONS

Please list all current medications, supplements, and vitamins you currently take. Please include the dosage/strength and frquency of your medications.

Medication/Supplement/Vitamins	Dosage or Strength	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

Please indicate which (if any) of the following blood thinners you are taking:

☐ Not on blood thinners.

☐ Aspirin	☐ Effient	☐ Plavix	☐ Ticlid
☐ Aggrenox	☐ Eliquis	☐ Pletal	☐ Warfarin
☐ Coumadin	☐ Lovenox	☐ Pradaxa	☐ Xarelto
			☐ Other:_____

DRUG ALLERGIES

☐ No known drug allergies.

Medication Name	Type of Reaction
1.	
2.	
3.	
4.	
5.	

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

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

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

How were you referred to our office?

☐ Referring Physician ☐ Employer ☐ Insurance Co.

☐ Family Member/Friend ☐ Website Name: _____ ☐ Other (please specify): _____