Patient Information Sheet

Patient's Name: ____
Last First Middle

Address: ____
Street or P.O. Box City ST Zip Code

Age: __________ Sex: M / F Marital Status: ________ Date of Birth: _______________

SS#: __________________________ Home Phone #: (_____) _________________ Work Phone #: (____) _________________

Patient's Employer: ______________________________________ Are You Retired? Yes / No

Employer's Business Address: ______________________________________

Name of Spouse: ____

Spouse's Employer: ______________________________________

Person Responsible For Payment of Bill: ______________________________________ Relationship: _______________________

Home Phone #: ___________________________ Work Phone #: ________________________________

If Patient Is Under 18 Years Old, Unmarried Or Still In School, List The Other Parent's Name That Is NOT Listed

Above: ____________________________________ DOB: ____________________ SS#: ______________________________

If This Is Work Related, Please Give Name and Phone # of Person To Call For Verification:

Name: _______________________________________ Phone #: (_____) __________________________

Primary Insurance Name: ____

Insurance Company Address: ______________________________________

Subscriber Or Insured's Name: ____________________________________ DOB: _______________________________

Subscriber #: ____________________________ Group #: __________________________________

How Is Insured Related To Patient? ______________________________________

Secondary Insurance Name: ______________________________________

Insurance Company Address: ______________________________________

Subscriber Or Insured's Name: ____________________________________ DOB: _______________________________

Subscriber #: ____________________________ Group #: __________________________________

How Is Insured Related To Patient? ______________________________________

Who Is Your Primary Care Physician? ______________________________________

Who Referred You To Our Office? ______________________________________

If Referred By A Physician, Please Give Name: ______________________________________

Address: ______________________________________

PLEASE READ CAREFULLY, THEN SIGN:

I have completed this form to the best of my ability and it is correct. I fully understand that I am responsible for payment of any and all services for this patient provided by this office and the method of payment I intend to use is:

(Please check one) PERSONAL CHECK: _____ CASH: _____ CREDIT CARD: _____

______________________________________ ______________________________
Signature of person responsible for payment Date

SHOULD IT BECOME NECESSARY FOR THIS OFFICE TO FILE INSURANCE, I AGREE TO ASSIGN THE INSURANCE BENEFITS TO THE PROVIDER OF SERVICES. I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS THAT MAY BE NECESSARY TO PROCESS ANY INSURANCE CLAIM FILED BY THIS OFFICE. I FULLY UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL SERVICES NOT COVERED BY MY INSURANCE.

______________________________________ ______________________________
Signature of person responsible for payment Date

Patient History Sheet — East Georgia Orthopedic Center Date: ______________________

Patient Name: ____________________________________ Age: ________ Ht: _________ Weight: _________

Drug Allergies: ____

Current Medication (Please list name, dosage, and frequency of administration) ____

____

____

____

Reason for today's visit: ____

If an injury, where did it occur? Work / Home / Auto / School / Other: _______________________________

Date of Injury: ____________________ Prior history of same or similar problem? Yes / No When? ___________________

Have you seen another doctor? Yes / No If so, who? ____

What treatment have you received? NONE

Medication?	Yes / No	Did this help?	Yes / No

If so, what kind? ____

Physical Therapy?	Yes / No	Did this help?	Yes / No
Chiropractor?	Yes / No	Did this help?	Yes / No
Injections?	Yes / No	Did this help?	Yes / No

What medical tests have been done?

X-rays	Yes / No	When & Where? ________________________	Did you bring these? Y / N
MRI	Yes / No	When & Where? ________________________	Did you bring these? Y / N
Blood Work	Yes / No	When & Where? ____	

Systems Review: Have you had any of the following?

Fever / Chills	Yes / No	Numbness / Tingling?	Yes / No
Weakness?	Yes / No	Appetite Loss?	Yes / No
Dizziness?	Yes / No	Vision Changes?	Yes / No
Rashes?	Yes / No	Itching?	Yes / No
Weight Loss?	Yes / No	Nausea / Vomiting?	Yes / No
Diarrhea?	Yes / No	Stomach Pain / Reflux?	Yes / No
Chest Pain?	Yes / No	Shortness of Breath?	Yes / No
Leg Swelling?	Yes / No	Blood in Urine?	Yes / No
Blood in Stool?	Yes / No	Painful Urination?	Yes / No
Hearing Loss?	Yes / No	Difficulty Swallowing	Yes / No
Depression?	Yes / No	Are You Pregnant?	Yes / No
Recent Illness?	Yes / No		

Past Surgical History:

Date:	Type of Surgery:	Surgeon's Name & Hospital:

Past Medical History	Patient	Family	Which Relative?
Allergies?	Y / N	Y / N	____________
Anesthesia Reactions?	Y / N	Y / N	____________
Arthritis?	Y / N	Y / N	____________
Asthma?	Y / N	Y / N	____________
Blood Clots?	Y / N	Y / N	____________
Bleeding / Blood Disorder?	Y / N	Y / N	____________
Cancer?	Y / N	Y / N	____________
Diabetes?	Y / N	Y / N	____________
Gout?	Y / N	Y / N	____________
Heart Failure?	Y / N	Y / N	____________
Heart Attack?	Y / N	Y / N	____________
Headaches?	Y / N	Y / N	____________
High Blood Pressure?	Y / N	Y / N	____________
HIV/Aids?	Y / N	Y / N	____________
Kidney Failure?	Y / N	Y / N	____________
Kidney Stones?	Y / N	Y / N	____________
Liver Disease?	Y / N	Y / N	____________
Lung Disease / COPD?	Y / N	Y / N	____________
Psychiatric Illness?	Y / N	Y / N	____________
Seizures?	Y / N	Y / N	____________
Skin Disorders / Psoriasis?	Y / N	Y / N	____________
Stroke / TIA's?	Y / N	Y / N	____________
Thyroid Disease?	Y / N	Y / N	____________
Tuberculosis?	Y / N	Y / N	____________
Ulcers / Reflux?	Y / N	Y / N	____________

Other Illnesses? ____

Social History:

Do you drink alcohol? Y / N How much & how often? ____________

Do you smoke tobacco? Y / N How much & how often? ____________

Use recreational drugs? Y / N What type & how often? ____________

Do you live at home? Y / N Do you live alone? Y / N

Occupation: ____________________ If disabled, give reason: ____________________

Married? Y / N Divorced Y / N

Children? Y / N Ages: ____________________

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE

Physician Signature	Date	Changes	Changes Noted
____________	Initial Visit	xxxxxx	xxxxxxxxxxxxxxxxxxx
____________	________	Y / N	Y / N
____________	________	Y / N	Y / N
____________	________	Y / N	Y / N
____________	________	Y / N	Y / N

<u>**East Georgia Orthopedic Center, PC**</u>

This is to certify that I have been given or offered a copy of the
NOTICE OF PRIVACY PRACTICES. Please sign only one place below.

I have accepted a copy of the **NOTICE OF PRIVACY PRACTICES**
(please ask the receptionist for your copy after signing):

____
PATIENT OR GUARDIAN

I have been offered a copy of the NOTICE OF PRIVACY PRACTICES
and I have declined to accept this.

____
PATIENT OR GUARDIAN