Registration Date: _____
Account Number: _____
Chart: _____

ATHENS ORTHOPEDIC CLINIC, P.A.
PATIENT INFORMATION

Name:_____ **Preferred(Nick) Name:** _____

Address: _____**City**_____**State**_____ **Zip**_____

Home Phone: _____ **Cell:** _____ **Email:**_____

Date of Birth:_____ **Age:** _____ **Social Security(last four #'s):** _____**Gender:** _____

Marital Status: O Single O Married O Divorced O Widowed

Primary Care Physician: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

Preferred Method of Contact: O Home O Cell O Email

RESPONSIBLE PARTY INFORMATION IF PATIENT IS A MINOR:

Name: _____**Relationship to Patient:** _____

Guarantor Address: _____ **City**_____ **State**____ **Zip**_____

Gender: _____ **DOB:** _____ **Social Security #:** _____

Home #: _____**Work #**_____ **Cell #**_____

Race: O American Indian O Asian O Black O Hawaiian O White O Decline

Ethnicity: O Non-Hispanic O Hispanic O Decline

Preferred Language: O English O French O Hindi O Italian O Spanish O Other: _____ **O Decline**

Primary Insurance: _____ **Subscriber:** _____

Policy #: _____ **Group #:** _____

Secondary Insurance: _____ **Subscriber:** _____

Policy #: _____ **Group #:** _____

Employer: _____ **Phone:** _____

Occupation: _____

Emergency Contact: _____**Relationship:** _____ **Phone #:** _____

I authorize Athens Orthopedic Clinic, P.A. to release to my insurance company, employer and/or referring physician, any information required in the course of my examination and treatment. I also authorize any physician, hospital, or clinic to provide details of my history to Athens Orthopedic Clinic, P.A. I hereby give consent to the providers of Athens Orthopedic Clinic, P.A., for medical treatment. I hereby assign payment directly to Athens Orthopedic Clinic, P.A. for medical benefits payable for these services. Should my claim(s) need an appeal, I authorize Athens Orthopedic Clinic, P.A. to appeal on my behalf. I understand that I am responsible for payment of services, including physician assistant and/or supply fees, rendered regardless of insurance coverage. If a patient is a minor, I am responsible for the payment of services. I also hereby acknowledge that I have received a copy of the financial policy and agree to adhere to all policies stated in this handout. Athens Orthopedic Clinic will charge a fee of 28% of the total balance due if my account is turned over to an outside collection agency. By signing below, I have read and understand the above.

_____ _____ _____
Patient/Responsible Signature **Print Name** **Date**

Registration Date: _____
Account Number: _____
Chart: _____

ATHENS ORTHOPEDIC CLINIC, P.A.
PATIENT INFORMATION
MEDICAL HISTORY

Problem You Are Having Today/Complaint: _____**O Right O Left O Both**

How Long Have You Had This Problem? _____ **When Did It Start?** _____

Is This Injury A Result Of: O Work O Sports O Auto Accident O Other O No Injury

If Work, Was This Reported To Your Employer? ____ Yes ____ No

If Injury, Please State In Your Own Words What Happened:

How Severe Is Your Pain On A Scale Of 0-10 With 10 Being The Most Severe? _____

Describe The Pain: O Dull O Throbbing O Sharp O Burning Timing: O All The Time O Just Sometimes

When Does The Pain/Problem Occur? (After Exercise or Night, etc.)_____

What Caused The Pain/Problem? _____

Are You Having Numbness, Swelling, Cracking, Popping, Grinding, Locking, etc. _____

What Makes The Pain/Problem Better?_____**Worse?**_____

Have You Seen Another Physician For This Pain/Problem Prior To Today?_____ **No** _____ **Yes**

If Yes, Who?_____

HEIGHT: _____***WEIGHT*****:** _____ **Dominant Hand? O Left O Right**

Have You Completed Any Therapy? ___ No ___ Yes

Are You Pregnant? _____Yes _____No If Yes, How Far Along? _____

Are You Up To Date On All Your Immunizations? _____Yes _____No Do You Have Osteoporosis? ___Yes ___No

Date of Last Bone Density Test _____ **Date of Last Tetanus:** _____

<u>Are You Currently Having or Have You Ever Had Any of The Following:</u>

o Atrial Fibrillation
o Asthma
o Anemia
o Arthritis
o Blood Clot/DVT
o Bronchitis
o Bleeding Disorder
o Back Trouble
o Blood Transfusion
o Chicken Pox
o Chronic Infections (MRSA)
o Cancer Type_____
o COPD
o Chest Pain/Angina
o Chronic Kidney Disease
o Congestive Heart Failure
o Diabetes
o Emphysema
o Epilepsy/ Seizure
o Glaucoma
o Gout
o Heart Attack
o Heart Disease
o Heart Murmur
o Hepatitis A B C
o High Blood Pressure/HTN
o High Cholesterol
o HIV or Aids
O inflammatory Arthroplasty
o Kidney Infections
o Low Blood Pressure
o Lupus/SLE
o Measles
o Migraine Headaches
o Mitral Valve Prolapse
o Overactive Thyroid
o Pacemaker
o Pneumonia
o Pulmonary Embolus/PF
o Rheumatoid Arthritis
o Rheumatic Fever
o Sleep Apnea
o Stroke/CVA
o Tuberculosis
o Underactive Thyroid
o Ulcers
o Urinary Disease/ Infection
Other:_____
_____
_____

Registration Date: _____
Account Number: _____
Chart: _____

ATHENS ORTHOPEDIC CLINIC, P.A.
PATIENT INFORMATION
SURGERY HISTORY

Have You Ever Had an Operation: ____ **No** _____ **Yes**

Please List

Date	Surgery	Body Part	Facility	Surgeon

Have You Ever Had Problems With General Anesthesia? ____**No** ___ **Yes (Explain)**

_____

Smoking Status:

- O Never Smoked
- O Every Day How Much Per Day _____
- O Occasional How Often _____
- O Former Smoker
  Date Started/Ended _____

Alcohol Intake:

- O Never drink
- O Every Day How Much Per Day _____
- O Occasional How Often _____
- O Moderately How Often _____
  Date Started/Ended _____

What type of tobacco: O Cigarette O Cigar O Other

Marital Status: O Single O Married O Divorced O Widowed

On average, how many days per week do you engage in moderate to strenuous exercise (like a brisk walk)? ____ **days**

On average, how many minutes do you engage in exercise at this level? _____ **minutes**

I intend to become more physically active in the next 6 months? ____**No** ___ **Yes**

Occupation: _____

Family History - If Yes, List Family Member, Age of Onset and If Deceased

Bleeding Problems/Clots/PE	___**No**	___**Yes**_____
Bowel/Bladder/Prostate	___**No**	___**Yes**_____
Lungs/Breathing	___**No**	___**Yes**_____
Cancer	___**No**	___**Yes**_____
Diabetes	___**No**	___**Yes**_____
Digestion/Heartburn	___**No**	___**Yes**_____
Epilepsy	___**No**	___**Yes**_____
Heart Problems	___**No**	___**Yes**_____
High Blood Pressure	___**No**	___**Yes**_____
HIV/AIDS	___**No**	___**Yes**_____

I hereby authorize the following individual(s) to have access to my medical records:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Registration Date: _____
Account Number: _____
Chart: _____

ATHENS ORTHOPEDIC CLINIC, P.A.
PATIENT INFORMATION
REVIEW OF SYSTEMS

PLEASE INDICATE IF YOU ARE HAVING ANY OF THESE PROBLEMS NOW. PLEASE ANSWER NO OR YES TO EACH LINE.

MUSCULOSKELETAL		URINARY		PSYCHIATRIC	
Joint Pain	No Yes	Frequent Urination	No Yes	Memory Loss or Confusion	No Yes
Joint Stiffness or Swelling	No Yes	Burning or Painful		Anxiety	No Yes
Muscle Pain or Cramps	No Yes	Urination	No Yes	Depression	No Yes
Back Pain	No Yes	Blood in Urine	No Yes		
Injury	No Yes	Incontinence or Dribbling	No Yes		

CONSTITUTIONAL SYMPTOMS		SKIN		GASTROINTESTINAL	
Recent Weight Change	No Yes	Rash or Itching	No Yes	Nausea or Vomiting	No Yes
Fever	No Yes	Changes in Skin	No Yes	Frequent Diarrhea	No Yes
Fatigue	No Yes	Varicose Veins	No Yes	Constipation	No Yes
Headaches	No Yes	Rectal Bleeding (Blood in Stool)	No Yes	Abdominal	No Yes
Heartburn	No Yes				

EARS/NOSE/MOUTH/THROAT		NEUROLOGICAL		RESPIRATORY	
Hearing Loss or Ringing	No Yes	Light Headed or Dizzy	No Yes	Chronic or Frequent Cough	No Yes
Nose Bleeds	No Yes	Numbness/Tingling	No Yes	Spitting Up Blood	No Yes
Bleeding Gums	No Yes	Sensations	No Yes	Shortness of Breath	No Yes
Sore Throat or Voice Change	No Yes	Tremors	No Yes	Wheezing	No Yes

CARDIOVASCULAR		ENDOCRINE		ALLERGIES
Chest Pain	No Yes	Excessive Thirst	No Yes	List Foods/Environmental Allergies
Palpitations	No Yes	Heat or Cold Intolerance	No Yes	_____
Exercise Intolerance	No Yes	Skin Becoming Drier	No Yes	_____

HEMATOLOGIC/LYMPHATIC

Enlarged Glands	No Yes	Bleeding or Bruising Tendency	No Yes

_____ _____
SIGNATURE OF PATIENT OR PARENT OF MINOR **DATE**

_____ _____
SIGNATURE OF PHYSICIAN **DATE**

Registration Date: _____
Account Number: _____
Chart: _____

ATHENS ORTHOPEDIC CLINIC, P.A.
PATIENT INFORMATION
MEDICATIONS

Pharmacy Name, Location and Number: _____

Medication/Supplements	Dose	Frequency	Reason for Medication	Restart/ Post OP
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are You Allergic To Any of The Following? Give Reaction if Yes

Penicillin ____No ____Yes_____

Codeine ____No ____Yes_____

Sulfa ____No ____Yes_____

Betadine/Iodine ____No ____Yes_____

Latex ____No ____Yes_____

Tape ____No ____Yes_____

Additional Allergies ____No ____Yes_____

(Include Drug, Food and Metal)_____

Patient Acknowledgement of Notice of Privacy Practices:

As required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have had the opportunity to review and/or request a copy of the Notice of Privacy Practices of Athens Orthopedic Clinic, P.A. Any questions or request for additional copies may be directed to: Athens Orthopedic Clinic, P.A., 1765 Old West Broad Street, Athens, GA 30606, Attn: Compliance Officer

Athens Orthopedic Clinic, P.A. ("AOC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AOC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

eRx CONSENT: ePrescribing software sends prescriptions over the internet to your pharmacy safely and securely, by applying the technology used by credit card companies, ePrescribing software helps protect your personal information while allowing your provider to access important data such as drug interactions and prescription history.

I agree that Athens Orthopedic Clinic may request and use my prescription medication history from other healthcare providers or pharmacy benefit payers for treatment purposes.

By signing below, I acknowledge that I have read and understand all of the above.

Signature of Patient or Guarantor: _____

Print Name: _____ **Date:** _____