Registration Date: _________________
Name:_____________________________
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 policyand 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: ________________
Name:___________________________
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: ________

Are You Currently Having or Have You Ever Had Any of The Following:

- 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: _________________
Name:____________________________
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: _________________
Name:_____________________________
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

Joint Pain No Yes
Joint Stiffness or Swelling No Yes
Muscle Pain or Cramps No Yes
Back Pain No Yes
Injury No Yes

URINARY

Frequent Urination No Yes
Burning or Painful Urination No Yes
Blood in Urine No Yes
Incontinence or Dribbling No Yes

PSYCHIATRIC

Memory Loss or Confusion No Yes
Anxiety No Yes
Depression No Yes

CONSTITUTIONAL SYMPTOMS

Recent Weight Change No Yes
Fever No Yes
Fatigue No Yes
Headaches No Yes
Heartburn No Yes

SKIN

Rash or Itching No Yes
Changes in Skin No Yes
Varicose Veins No Yes
Rectal Bleeding (Blood in Stool) No Yes

GASTROINTESTINAL

Nausea or Vomiting No Yes
Frequent Diarrhea No Yes
Constipation No Yes
Abdominal No Yes

EARS/NOSE/MOUTH/THROAT

Hearing Loss or Ringing No Yes
Nose Bleeds No Yes
Bleeding Gums No Yes
Sore Throat or Voice Change No Yes

NEUROLOGICAL

Light Headed or Dizzy No Yes
Numbness/Tingling No Yes
Sensations No Yes
Tremors No Yes

RESPIRATORY

Chronic or Frequent Cough No Yes
Spitting Up Blood No Yes
Shortness of Breath No Yes
Wheezing No Yes

CARDIOVASCULAR

Chest Pain No Yes
Palpitations No Yes
Exercise Intolerance No Yes

ENDOCRINE

Excessive Thirst No Yes
Heat or Cold Intolerance No Yes
Skin Becoming Drier No Yes

ALLERGIES

List Foods/Environmental Allergies
____
____

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: _________________
Name:__________ _________________
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: ___________________________