

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: Single Married Divorced Widowed

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Preferred Method of Contact: Home Cell 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: American Indian Asian Black Hawaiian White Decline

Ethnicity: Non-Hispanic Hispanic Decline

Preferred Language: English French Hindi Italian Spanish Other: _____ 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

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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 Right O Left

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:

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

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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:

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

Alcohol Intake:

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

What type of tobacco: Cigarette Cigar Other

Marital Status: Single Married Divorced 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

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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: _____