SC Sports Medicine & Orthopaedic Center
Patient Information Form

Patient First Name: ___________________________________ MI:_______ Last Name:____________________________________

Age: _______ Date of Birth: __________________ Sex: M or F SS#: _________-_______ -_________ Marital Status:__________

Address: ____Apt#:____ City: ______________________State: _____Zip:________

Home Phone: ( ) ____________________ Work Phone: ( ) _____________ Ext: ______ Cell: ( )_____________________

Email address: ____

Employer/School: ____Occupation:__________________________

Employer/School Address: ____

Name of Spouse: ____ DOB: _________________ SS#:____________________

Spouse's Employer: ____ Phone #: ( ) _________________________

Family/Primary Care Doctor: _____________________________________ Referring Doctor: _________________________________

In case of an emergency please notify: ____
Name Relationship Phone #

How did you hear about us? ____

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IF THE PATIENT IS A CHILD OR A FULL TIME STUDENT, PLEASE COMPLETE THIS SECTION

Name of RESPONSIBLE party for this patient's bill: ____
(Note: Must be self, parent, or legal guardian)
Mailing Address: ______________________________________Apt#:____ City: ____________________State: _____Zip:________

Name of School: _______________________________________ Address: ____

Mother's Name: ___________________________________ Date of Birth: ____________________ SS#: ________-_______-_______

Mother's Employer: ____ Phone #: ( )__________________________

Father's Name: ___________________________________ Date of Birth: ____________________ SS#: ________-_______-_______

Father's Employer: ____ Phone #: ( ) __________________________

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Pharmacy Name: ___________________________ **Address #:** ____________________ **Phone #:** ___________________

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Primary Insurance: ___________________________________ID #:__________________________Grp #:____________________
Insured DOB:____ Insured SS#:____
Secondary Insurance: _________________________________ID #:__________________________Grp #:__________________
Insured DOB:____ Insured SS#:____

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ACCIDENT QUESTIONNAIRE

NO Accident__________ **Auto Accident**_________ **Work Related**___________ **Other Accident**__________
Date of the Injury:____________________________________ Where did Injury Occur?_________________________________

How did the Injury or Accident Occur? ____

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PLEASE READ AND SIGN SECTIONS I, II AND SECTION III OR IV PER INSURANCE TYPE

I. Financial Policy & Payment Responsibility: Payment for medical services is the responsibility of the patient or, in the case of a minor, the signed responsible party. Our office will file for insurance benefits for plans in which we **do participate**. Payment for deductible, co-insurance, and co-payment amounts will be collected from the patient at the time of service. If your insurance plan does not pay your medical services within 30 days, all charges may be due and payable in full from the patient. Your help in seeing that your insurance pays for your medical services within the specified time period is appreciated. I hereby acknowledge and accept full and final responsibility for payment of charges for medical services rendered. I understand that if payments for services rendered by this facility are not met, my account could be referred to an outside collection agency for further collection activity.

If my financial responsibility is not met when payment is due, SC SportsMedicine reserves the right to charge interest at the rate of 8% on any past due balance. If the patient no shows, or cancels their appointment repeatedly, their treating physician reserves the right to charge a $100 no show or frequent cancellation fee to the patient's bill.

For insurance plans in which we **do not participate,** our office will file a claim to your insurance plan as a courtesy. Full payment of charges will be collected from the patient at the time of service, unless special arrangements have been approved in advance.

We reserve the right to obtain a credit report and/or report to credit bureaus the status of your account due to delinquent account balances. A fee of $25.00 will be charged to your account for Returned Checks.

Patient or Responsible Party Signature: ____Date:__________

II. Consent for Treatment & Medical Release Authorization: I hereby consent to treatment for myself, my child, or named minor, for whom I am legally responsible. I authorize South Carolina Sports Medicine & Orthopaedic Center to release any medical information to any referring physician, other health care providers, hospitals and medical facilities, and to my insurance carriers and for the purpose of treatment, payment and health care operation. The release of medical information for insurance claims, the release of past medical payment history, if requested, is authorized. I understand that this information may include reference to psychiatric care, sexual assault, alcohol and/or drug abuse, and results of tests for all infectious diseases including AIDS/HIV. I furthermore, authorize South Carolina Sports Medicine and Orthopaedic Center's physicians and staff to discuss my Protected Health Information (PHI) in the presence of the family and visitors that accompany me during my visits.

Patient or Responsible Party Signature: ____Date:___________

III. Assignment of Insurance Benefits: I hereby assign and authorize payment to South Carolina Sports Medicine and Orthopaedic Center of all medical and surgical benefits to which I am entitled, including health insurance benefits, major medical benefits, and third party liability coverage including personal injury protection (PIP) benefits and other medical payment coverage for which I am entitled. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I hereby authorize South Carolina Sports Medicine and Orthopaedic Center to release all information necessary to secure payment of insurance benefits**. I understand that I am financially responsible for all charges whether or not paid by said insurance(s).**

Patient or Responsible Party Signature: ____Date:___________

IV. Medicare Insurance (SIGNATURE ON FILE): I request payment of authorized Medicare benefits be made payable to South Caroline Sports Medicine & Orthopaedic Center for any services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 forms or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and **non-covered** services. I authorize Health Care Financing Administration to release information to process claims for Medigap or secondary insurance.

Patient or Responsible Party Signature: ____Date:___________

☐ ***Please Initial box to acknowledge receipt/understanding of HIPAA information.***

*** If you would like to specify a person(s) rights to the privacy of your account please see the front desk receptionist for an additional form ***

SC Sports Medicine & Orthopaedic Center
Medical History

Date: ______/______/______ Patient Name ____ Goes by _____________

Patient Age _________ Ht_________ Wt_________ Referring Physician____

Your reason for today's visit – What specific body part is causing the problem? (Please specify right or left) ____________________

____

Accident Date/Onset of Problem _______________ How did the accident or injury occur?__________________________________

Have X-Rays been taken for this problem? YES / NO When:______________________ Where:__________________________
Do you have your x-rays with you? YES / NO

Medical History: Do you or any of your immediate family members have any of the following?

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	Y or N	Y or N	High Blood Pressure	Y or N	Y or N
Alcoholism	Y or N	Y or N	Kidney Disease	Y or N	Y or N
Anemia	Y or N	Y or N	Liver Disease	Y or N	Y or N
Arthritis	Y or N	Y or N	Lung Disease	Y or N	Y or N
Bleeding tend.	Y or N	Y or N	Muscular Disease	Y or N	Y or N
Blood clots (lung/leg)	Y or N	Y or N	Prostate Disease	Y or N	Y or N
Blood transfusion	Y or N	Y or N	Seizures	Y or N	Y or N
Cancer	Y or N	Y or N	Sickle Cell Disease	Y or N	Y or N
Circulation probs.	Y or N	Y or N	Stroke	Y or N	Y or N
Diabetes	Y or N	Y or N	Stomach Ulcers	Y or N	Y or N
Gout	Y or N	Y or N	Thyroid Disease	Y or N	Y or N
Heart attack (MI)	Y or N	Y or N	Tuberculosis	Y or N	Y or N
Heart disease	Y or N	Y or N	Urinary tract infections	Y or N	Y or N
Heart murmur	Y or N	Y or N	Varicose veins	Y or N	Y or N
Hepatitis	Y or N	Y or N	Other ______________________________________		

Comments____

Family History: (Please list age of relative below. If not living, list cause of death.) Ex: Father 71 heart attack

Mother's age ____ Brother(s) / Sister(s) age ___________________________________

Father's age ____ Children ____

Current Medications: (Also include over the counter medicines and birth control pills.)

Name	Dose	How Often?	Name	Dose	How Often?
1.____________			4.____________		
2.____________			5.____________		
3.____________			6.____________		

***** CONTINUED *****

Medical History (continued) **Patient Name** ____________________________________

Have you ever taken cortisone pills? Yes or No / If yes, when? ___________________________ How long? _________________
Have you ever taken cortisone shots? Yes or No / If yes, how many? _____________ Why? ________________________________
Date of last tetanus shot? ____
Females: Date of your last period ____/____/____ Are you pregnant? Y / N / possibly / Are you breastfeeding? Y or N

Allergies: Ex: Penicillin Hives

Name of Drug / food/ material	Reaction	Name of Drug / food/ material	Reaction
1.		4.	
2.		5.	
3.		6.	

Surgical History: Please list in order by year. Ex: Tonsils removed 1964

Name of Procedure	Year	Name of Procedure	Year
1.		4.	
2.		5.	
3.		6.	

Did you have any surgical or anesthetic complications? (If so, please describe) ____

____

Social History: Please answer all questions completely.

Occupation ____ Marital Status ______________________________

Tobacco Use Yes or No Type____________________________ Packs per day ________________ How long ________________

Alcohol Yes or No Type _____________________________ Amount per week ____

Drug Use Yes or No Type ____________________________ Amount per week ____

Do you participate in sports or other activities? Yes or No / If yes, please list ____

***Review of Systems: Do you experience any of the following? Please circle all that apply.**

General: fever, chills, recent weight loss or gain

Eyes: blurring, double vision, wear glasses, wear contact lenses

Ear, Nose & Throat: deafness, sinusitis, ringing in ears, hoarseness, dizziness, dental infections, sore throat, dentures

Cardiac: chest pain, palpitations, irregular heart beats, swelling in legs, fainting spells

Respiratory: short of breath, cough, wheezing

Intestinal: nausea, vomiting, decreased appetite, diarrhea, constipation, abdominal pain, heartburn, blood in stool

Urinary: burning with urination, urinating frequently, notice a sudden urgency to urinate, difficulty starting stream, incontinence (lack of controlling urine)

Breast: lumps

Musculoskeletal: stiffness, muscle or joint pain, joint swelling

Skin: rashes, sores, tattoos, scars, masses, ulcers, itching

Neurologic: problems with speech, difficulty swallowing, numbness, tingling, weakness, visual changes, balance/coordination problems

Psychiatric: depression, nervousness, eating disorder, hallucinations, sleep disturbances,

Endocrine: excessive thirst, excessive urination, heat or cold intolerance

Hematology/Lymphatic: bleeding tendency, swollen glands, night sweats