

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 #
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How did you hear about us? _____

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 #: () _____

Pharmacy Name: _____ **Address #:** _____ **Phone #:** _____

Primary Insurance: _____ **ID #:** _____ **Grp #:** _____

Insured DOB: _____ Insured SS#: _____

Secondary Insurance: _____ **ID #:** _____ **Grp #:** _____

Insured DOB: _____ Insured SS#: _____

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? _____

HOME HEALTH/SKILLED NURSING FACILITY QUESTIONNAIRE

If you are currently receiving Home Health or residing in a skilled nursing facility (nursing home or rehabilitation facility), that entity may be responsible to pay for the services you receive today. It's important that we have the correct information on file for this reason.

Are you currently receiving Home Health? ____ **yes** ____ **no**

If yes, which agency is providing your Home Health? _____

Are you currently residing in a skilled nursing facility? ____ **yes** ____ **no**

If yes, what is the name of your skilled nursing facility? _____

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 Sports Medicine 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 Carolina 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	Hepatitis	Y or N	Y or N
Alcoholism	Y or N	Y or N	High Blood Pressure	Y or N	Y or N
Anemia	Y or N	Y or N	Kidney Disease	Y or N	Y or N
Arthritis	Y or N	Y or N	Liver Disease	Y or N	Y or N
Bleeding tend.	Y or N	Y or N	Lung Disease	Y or N	Y or N
Blood clots (lung/leg)	Y or N	Y or N	Muscular Disease	Y or N	Y or N
Blood transfusion	Y or N	Y or N	Prostate Disease	Y or N	Y or N
Cancer	Y or N	Y or N	Seizure	Y or N	Y or N
Circulation problems	Y or N	Y or N	Sickle Cell Disease	Y or N	Y or N
Dementia	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

Comments/Other _____

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. _____		

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