



GEORGIA
Hand, Shoulder & Elbow

PATIENT INFORMATION GEORGIA HAND, SHOULDER, & ELBOW

Please complete this form. It is a **confidential** part of your medical record. If you have any questions about this form, please ask our front desk personnel. You must fill out **completely** prior to being seen.

DEMOGRAPHICS

Patient Name: _____ **Date:** _____
(Last) (First) (M.I.)

(Circle)

Sex: M/F **Date of Birth:** _____ **Age:** _____ **Social Security Number** _____

Home Address: _____
(Street) (City) (State) (Zip)

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

(Circle One)

Marital Status: Single/Married/Divorced/Widow **Spouse Name:** _____ **Race:** _____

Work Related: Yes/No **Specific Job:** _____

Patients's Occupation: _____ **Name of Employer** _____

Years of Service _____

(Circle One)

Current Work Status: Regular Duty/Light Duty/Off Work

Hobbies/Musical Instruments: _____

INSURANCE INFORMATION

(Circle One)

Do you have insurance? Yes No

Primary Insurance Coverage: _____ **Policy Holder:** _____

Policy Holder Social Security#: _____ **Relationship to Policy Holder:** _____

ID or Plan#: _____ **Policy Holder DOB:** _____

Group #: _____

Secondary Insurance Coverage: _____ **Policy Holder:** _____

Policy Holder Social Security#: _____ **Relationship to Policy Holder:** _____

ID or Plan#: _____ **Policy Holder DOB:** _____

Group #: _____

Insured's Employer: _____ **Employer Phone#:** _____

If patient is a MINOR, Responsible Party Name: _____ **Relationship to patient:** _____

Address _____

Responsible Party Home Phone#: _____ **Work Phone #:** _____

Patient Name: _____

I was referred by: _____

Pharmacy Name: _____ Phone Number: _____

Chief reason for today's evaluation: _____

I am Right/Left Handed Date of Injury or onset of condition : _____

Describe accident or injury: _____

Describe all previous treatments for your condition _____

Severity of Symptoms from 1 to 10: _____

Body parts affected: R/L__Hand____Wrist____Forearm____Elbow____Shoulder____Neck____

GENERAL INFORMATION

Please List Your Medication Allergies

Reaction

No Known Drug Allergies

Please List Your Current Medications and Dosage (Prescriptions, Over-the-Counter, and Herbal)

None

Please List Previous Surgeries:

Date of Surgery:

1. _____
2. _____
3. _____
4. _____

Patient Name: _____

Are you pregnant:	YES	NO
Do you take prescription blood thinners (Coumadin, Plavix, or Lovenox)?	YES	NO
Do you take aspirin or anti-inflammatory medicines every day?	YES	NO
Do you have heart valve problems?	YES	NO
Have you had a joint or heart valve replacement?	YES	NO
Are you allergic to latex?	YES	NO
Are you allergic to intravenous contrast (dye)?	YES	NO

MEDICAL HISTORY: (REVIEW OF SYSTEMS)

EYES

Wear Contacts	YES	NO
Wear Glasses	YES	NO
Glaucoma	YES	NO
Cataracts	YES	NO

EARS/NOSE/THROAT

Hearing loss or ringing	YES	NO
Sinus Congestion	YES	NO

ENDOCRINE

Diabetes	YES	NO
Hypothyroidism	YES	NO
Hyperthyroidism	YES	NO
Hypercholestermia	YES	NO

CARDIOVASCULAR

Hypertension	YES	NO
Chest Pain	YES	NO
Heart Attack	YES	NO
Congestive Heart Failure	YES	NO
Abnormal EKG in past	YES	NO
Irregular Heart Beat	YES	NO
Mitral Valve Prolapse	YES	NO
Coronary Artery Disorder	YES	NO

RESPIRATORY

Asthma	YES	NO
Emphysema	YES	NO
Bronchitis	YES	NO
Chronic Cough	YES	NO
Sleep Apnea	YES	NO
I use CPAP	YES	NO
COPD	YES	NO

GASTROINTESTINAL

Bleeding Ulcers	YES	NO
IBS	YES	NO
Acid Reflux	YES	NO
Gallstones	YES	NO

GENITOURINARY

Kidney Stones	YES	NO
Kidney Failure	YES	NO

MUSCULOSKELETAL

Muscle Weakness	YES	NO
Osteoporosis	YES	NO
Osteopenia	YES	NO
Osteoarthritis	YES	NO

RHEUMATOLOGIC DISEASE

Rheumatoid Arthritis	YES	NO
Systemic Lupus Erythematosus	YES	NO
Psoriatic Arthritis	YES	NO
Scleroderma	YES	NO
Sjörger's Disease	YES	NO
Other:		

NEUROLOGICAL

Stroke	YES	NO
Seizure Disorder	YES	NO
Paralysis	YES	NO
Other:	YES	NO

DERMATOLOGICAL (Skin)

Psoriasis	YES	NO
Eczema	YES	NO
Acne	YES	NO

PSYCHIATRIC

Depression	YES	NO
Anxiety Disorder	YES	NO
Other:		

HEMATOLOGICAL/LYMPHATIC

Leukemia	YES	NO
Lymphoma	YES	NO
HIV Positive	YES	NO
Von Willebrand's Disease	YES	NO
Sickle Cell Disease	YES	NO
Sickle Trait	YES	NO
Hepatitis A, B, or C	YES	NO
Liver Disease	YES	NO

CANCER, If Yes Please List:

USE OF ALCOHOL: Never/Social/Daily

**USE OF TOBACCO: Never/Former/
Current, Packs/Day _____**

FINANCIAL POLICY

At Georgia Hand, Shoulder & Elbow we are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines:

1. Payment is due at the time of service.
2. We will file your insurance for you if we are a participating provider of your plan. We will make every attempt to verify your coverage at the time of service. Since insurance plans cannot guarantee eligibility or benefits, we cannot do so either. You will be responsible for any and all services in excess of your insurance limits, as well as all non-covered services.
3. All co-payments are due at the time of service.
4. If we are not participating providers of your plan, and you do not have out-of-network benefits, payment in full is expected today. Please understand that if we do not participate in your plan, any associated surgery, testing or therapy may not be covered as well.
5. Claims for patients with insurance plans that have out-of-network benefits will be filed. Any outstanding claims not paid by insurance within sixty (60) days will be due by the patient.
6. Patients covered under Workman's Compensation may be responsible for payment if the claim is controverted.
7. **All copayments, unmet deductibles and any amounts deemed by your insurance policy that are the responsibility of the patient are due and payable prior to surgery.**

I have read and understand the Financial Policy.

Signature

Date

NOTICE OF PRIVACY PRACTICES

**As required by the Privacy Regulations created as a result of the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

I have been given the opportunity to review/obtain a copy of Georgia Hand, Shoulder & Elbow's Notice of Privacy Practices.

Signature

Date