

**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 the form, please ask our front desk personnel. You must fill out the form **completely** prior to being seen.

**DEMOGRAPHICS**

Patient Name: _____		<small>(Last)</small>	<small>(First)</small>	<small>(M.I.)</small>	Date: _____
Sex: M/F _____	Date of Birth: _____	Age: _____	Social Security Number: _____		
Home Address: _____		<small>(Street)</small>	<small>(City)</small>	<small>(State)</small>	<small>(Zip)</small>
Home Phone #:( ) _____	Work Phone #:( ) _____	Cell Phone #:( ) _____			
Marital Status: _____	<small>(Circle One)</small>	Spouse Name: _____		<small>(If Applicable)</small>	Race: _____
Patient's Occupation: _____		Duties: _____			
Years of Service: _____	Current Work Status: <input type="checkbox"/> Regular Duty		<input type="checkbox"/> Light Duty	<input type="checkbox"/> Off work	

**INSURANCE INFORMATION**

Do you have insurance? _____	<small>(Circle)</small>	Yes	No
<b>Primary Insurance Coverage:</b> _____		Policy Holder: _____	
Policy Holder Social Security #: _____		Relationship to Policy Holder: _____	
ID or Plan #: _____		Policy Holder DOB: _____	
<b>Secondary Insurance Coverage:</b> _____		Policy Holder: _____	
Policy Holder Social Security #: _____		Relationship to Policy Holder: _____	
ID or Plan #: _____			
Insured's Employer _____		Employer Phone #: ( ) _____	
Employer Address: _____		<small>(Street)</small>	<small>(City)</small>
_____		<small>(State)</small>	<small>(Zip)</small>
If patient is a <b>MINOR</b> , Responsible Party Name: _____		Relationship to Patient: _____	
Address: _____		<small>(Street)</small>	<small>(City)</small>
_____		<small>(State)</small>	<small>(Zip)</small>
Responsible Party Home Phone #: ( ) _____		Work Phone #: ( ) _____	
I was referred by: _____			
<b>Chief reason for today's evaluation:</b> _____			
I am Right/Left Handed _____			
Date of Injury or onset of condition: _____		Work Related? Yes	No
Describe accident or injury: _____			
Body Parts affected: R/L	Hand	Wrist	Forearm
			Arm
			Shoulder
			Neck
Previous treatment for this condition: _____			
What makes it better? 1.		2.	
	3.		4.
What makes it worse? 1.		2.	
	3.		4.
Hobbies: _____			
Musical Instruments: _____		I play _____ Times/Month	

**GENERAL MEDICAL INFORMATION**

**DRUG ALLERGIES**

Medication

Reaction (what happens when you take it)

Current medications and dosage:  None

- 1.
- 2.
- 3.
- 4.

Current medical problems/Date of onset:  None

- 1.
- 2.
- 3.
- 4.

Previous Surgeries:  None

- 1.
- 2.
- 3.

Are you pregnant?    Yes        No

**REVIEW OF SYSTEMS (Have you recently had trouble with...)**

	Yes	No	
Recent weight loss	<input type="checkbox"/>	<input type="checkbox"/>	How much lost in last 3 months _____ pounds
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Glasses <input type="checkbox"/> Contact lenses
Ears, nose, throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sinus Congestion
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Murmur
			<input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Abnormal electrocardiogram in past
			<input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Hypertension
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic bronchitis <input type="checkbox"/> Chronic cough
Smoke	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list # of packs per day ____ I started smoking in 19 ____
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bleeding <input type="checkbox"/> Ulcers <input type="checkbox"/> Liver Disease (hepatitis) <input type="checkbox"/> Yellow jaundice
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list # beers/drinks per day _____
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Kidney stones <input type="checkbox"/> Kidney failure
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Muscle weakness
Integumentary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Skin <input type="checkbox"/> Breast
Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Stroke <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Paralysis
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Depression <input type="checkbox"/> Other
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Hyperthyroidism
			<input type="checkbox"/> Hyperparathyroidism
Hematologic/ Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> HIV Positive
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	If yes, to what?
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what type?

**WORK HISTORY**

Name of Employer: \_\_\_\_\_ Years of Service: \_\_\_\_\_

Number of days missed this year secondary to your current condition: \_\_\_\_\_

Specific mechanism of injury if work related: \_\_\_\_\_

Specific Job: \_\_\_\_\_ | Reviewed by physician \_\_\_\_\_

## 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. 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.
2. All co-payments are due at the time of service.
3. 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.
4. 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.
5. Payment plans may be set up for subsequent visits if arrangements are made in advance.
6. Patients covered under Workman's Compensation may be responsible for payment if the claim is controverted.

I have read and understand the Financial Policy.

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Signature

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Date

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## 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.

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Signature

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Date