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 Name) (First Name) (M.I)

Sex: ○M ○F Date of Birth: ___________ Age: _____ Social Security Number: ____________________
Race: ____________________

Home Address: ______________________________ Home Phone#: ____________________
______________________________ Work Phone#: ____________________
City, State, Zip: ______________________, ___ ________ Cell Phone#: ____________________

Marital Status: ○Single ○Married ○Divorced ○Widow Spouse Name: ______________________

Work Related: ○ Yes ○No Specific Job: ____

Patient's Occupation: ______________________________ Name of Employer: ________________________

Years of Service: _________

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

Hobbies/Musical Instruments:____

INSURANCE INFORMATION

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 #: ____________________

Print Form

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: Right: __ Hand __ Wrist __ Forearm __ Elbow __ Shoulder   Neck: __

Left: __ Hand __ Wrist __ Forearm __ Elbow __ Shoulder

GENERAL INFORMATION

Please List Your Medication Allergies   **Reaction**   **__ No Known Drug Allergies**

1. _____________________________ ____
2. _____________________________ ____
3. _____________________________ ____
4. _____________________________ ____

Please List Your Current Medications and Dosage (Prescriptions, Over-the-Counter, and Herbal)   **__ None**

1. ____
2. ____
3. ____
4. ____

Please List Previous Surgeries: **Date of Surgery**

1. ____ ____________
2. ____ ____________
3. ____ ____________
4. ____ ____________

Print Form

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

GASTROINSTESTINAL

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
Sjörgen'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: ____

Print Form

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, 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 as a courtesy and any reimbursement will come to you directly from the insurance company.
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

CONSENT TO CALL

I consent to receive calls from Georgia Hand, Shoulder & Elbow for my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

_____________________________________ _________________________

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 1966 (HIPAA)

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

_____________________________________ _________________________

Signature Date

Print Form