Carolina Orthopaedic & Neurosurgical Associates

Patient Information

First: _____ Middle: _____ Last: _____

Mailing Address _____ City: _____ State: _____ Zip: _____

Home Phone #:_____ Cell Phone #: _____☺**EMAIL**: _____

Date of Birth: _____ Age: _____ SS#: _____ Gender: _____

Marital Status: _____ Race: _____ Is the Patient a Student: ☐ Yes ☐ No

* If a Prescription should be given today, which Pharmacy & Location:_____

Pharmacy Benefits Carrier :_____**(Please give card to Receptionist)**

Patient's Employer or School: _____ Work Phone #: _____

Occupation: _____ □ Full Time □ Part-time

What body part is injured or painful:_____ □ Right □ Left Date of Injury _____

If an Accident, was it: ☐ WORK RELATED ☐ AUTOMOBILE ACCIDENT ☐ OTHER INJURY: _____

Referred By: (Physician, Hospital, ER, Friend, etc.): _____

Who is your Primary Care Physician: _____

If the Patient is a Minor – provide guardian information:

Parent / Responsible Person: _____

Address: _____ *Phone #:*_____ *Date of Birth:* _____ *SS#:* _____

REQUIRED:

Emergency Contact Person: _____ Relationship: _____ Phone #: _____

Does the patient have Advance Directives? (Living Will) □ YES □ NO

Primary Insurance Information

Insurance Company: _____ Insured's Name: _____

Insured's SS#: _____ Insured's DOB: _____ Insured's Group / Policy #: _____

Secondary Insurance / Supplemental Insurance

Insurance Company: _____ Insured's Name: _____

Insured's SS #: _____ Insured's DOB: _____ Insured's Group / Policy #: _____

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance. I hereby assign, transfer, and set over to CONA all of my rights, title, and interest to my medical reimbursement benefits under insurance(s) policy listed above. I understand that CONA has the right to refuse or accept assignment of such benefit. Thus, if the account balance is not satisfied within 60 days after the first notification, the account may be referred to a collection agency. I authorize the release of information to my referring or family physician and/or that which is necessary to file claims to the insurance carrier and the billing of my account for payment. I understand that you may be transmitting any records electronically, and I absolve all parties of any liability to such of said records.

Signature: _____ Date: _____

UNIVERSAL MEDICATION FORM

Today's Date: _____

Patient's Name:	
Patient's Date of Birth:	
Phone #:	
Allergic To: Reaction:	Allergic To: Reaction:
Allergic To: Reaction:	Allergic To: Reaction:
Allergic To: Reaction:	Allergic To: Reaction:

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

Date Prescribed	**Name of Medication/Dosage**	**Directions / How often taken**	**Prescribing Doctor's Name Reason for RX**	**Date RX Stopped** ***If Applicable***

Carolina Orthopaedic & Neurosurgical Associates

1330 Boiling Springs Rd., Suite 1600
Spartanburg, SC 29303
864-582-6396
Fax 864-542-2939

115 Deacon Tiller Court
Duncan, SC 29334
864-721-0025
Fax 864-721-0035

1075 Boiling Springs Road
Spartanburg, SC 29303
864-583-7265
Fax 864-591-0422

HIPAA Consent / Authorization of Use & Disclosure of PHI / Notice of Privacy

Patient Name: _____ Date of Birth: _____

Authorization to Release Medical and Appointment Information

I give my permission to release any of my PHI (Protected Health Information) to the names below. Without this authorization, we will not be able to disclose any information about you, your appointment, your bill(s), or your treatment at CONA to anyone but you, the patient, your insurance company or referring / treating physician(s).

Name:	Relationship to You:	Type of Info to Release; **(All, Or indicate just Medical, includes previous Medication History, Appt or Financial)**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Contact Information

May we contact you and leave information regarding appointments, treatment, as well as other pertinent medical information in the following methods listed below: _____ Yes _____ No

If yes, Check all that apply:

_____ Home Phone _____ Answering Machine _____ Work _____ Mail
_____ Cell _____ Text Message Reminder of Appts. _____ Email

Acknowledgement of Receipt of **Notice of Privacy Practices and Patient's Rights & Responsibilities**

I have received a copy of the Notice of Privacy Practices. The notice provides detailed information of how my health information may be used or disclosed. I have been provided the Patient's & Responsibilities explaining the standards that are required regarding both. I understand I should read both carefully. I am aware that these notices may be changed and a copy of any revised notice can be provided at any time.

Patient / Guardian Signature: _____

Date: _____

Do not write, stamp, punch holes or affix a sticker in this area.
To reproduce, follow the printing instructions.

Direction of Feed

New Patient / Return Patient New Problem

Please answer every question

STAFF: *Handwritten items must be entered* ***MANUALLY****.*
Fold only on the dotted lines.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH Month Day Year

INJURY / CONDITION

Was this the result of an injury? ◯ yes ◯ no **Date of injury:** _____

If yes, where did it happen? ◯ home ◯ school ◯ auto ◯ work ◯ public **other:** _____

Are you claiming as Workers' Compensation? ◯ yes ◯ no

TYPE OF PROBLEM

◯ pain ◯ weakness ◯ swelling **other:**
◯ sprain / strain ◯ fracture ◯ numbness / tingling _____

LOCATION OF YOUR INJURY / CONDITION

please fold on dotted line

	RIGHT	LEFT	BOTH SIDES
collar bone	◯	◯	◯
shoulder	◯	◯	◯
arm	◯	◯	◯
elbow	◯	◯	◯
wrist	◯	◯	◯
hand	◯	◯	◯
fingers	◯	◯	◯
pelvis	◯	◯	◯

	RIGHT	LEFT	BOTH SIDES
hip	◯	◯	◯
leg	◯	◯	◯
knee	◯	◯	◯
ankle	◯	◯	◯
foot	◯	◯	◯
toes	◯	◯	◯
back pain	◯	◯	◯
neck pain	◯	◯	◯

other: _____

PREVIOUS TREATMENT

Have you been seen by any other doctor for this injury / condition? ◯ yes ◯ no

If yes, what type? ◯ Orthopaedic Doctor ◯ Chiropractor ◯ Family Doctor / Primary Care Physician ◯ Occupational Medicine **other:** _____

When did you see the other physician? ◯ within the last month ◯ greater than 6 months ◯ less than 6 months ◯ 1 or more years

Have you had any of the following for this problem? ◯ **NONE** ◯ MRI ◯ Bone Scan ◯ X-ray ◯ CT ◯ EMG / NCS (Electromyography / Nerve Conduction Study)

other: _____

please fold on dotted line

Have you received any of the following treatments for this problem? (Mark all that apply. If none, mark "**NONE**".)

◯ Injection	**If yes, did it help?**	◯ yes	◯ no
◯ Medications	**If yes, did it help?**	◯ yes	◯ no
◯ Physical Therapy	**If yes, did it help?**	◯ yes	◯ no
◯ Surgery	**If yes, did it help?**	◯ yes	◯ no
◯ **NONE**			

TOBACCO USE

Please describe your cigarette smoking status: ◯ never smoked ◯ former smoker ◯ current smoker (every day) ◯ current smoker (some days)

If you smoke, how many packs per day? ◯ <½ ◯ ½ ◯ 1 ◯ 1½ ◯ 2 ◯ >2

Do you use any smokeless tobacco products? ◯ chewing tobacco (dip) ◯ snuff ◯ vapor (e-cigarettes)

Do not write, stamp, punch holes or affix a sticker in this area. To reproduce, follow the printing instructions.

Direction of Feed

Medical History & Review of Systems

Please answer every question

STAFF: *Handwritten items must be entered* ***MANUALLY****. Fold only on dotted lines.*

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH (Month / Day / Year)

SOCIAL HISTORY

What is your marital status?
○ single ○ partnered ○ divorced
○ married ○ separated ○ widowed

Who lives in your household with you?
○ live alone ○ sibling(s) ○ roommate(s)
○ spouse / partner ○ child(ren) ○ assisted living
○ parent(s) ○ grandparent(s) ○ campus housing

How many children do you have?
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11+

Do you have any of the following?
○ pacemaker ○ metal in body (where): _____ ○ NONE
○ hearing aid

please fold on dotted line

What is your occupation? _____

Do you drink alcohol? ○ yes ○ no ○ in the past

If yes, how many drinks per week? ○ occasionally ○ 1 – 3 ○ 4 – 7 ○ 8 – 14

Do you exercise? ○ yes ○ no

If yes, how many times per week? ○ occasionally ○ 1 – 3 ○ 4 – 7 ○ 8 – 14

REVIEW OF SYSTEMS

Please indicate if you CURRENTLY are experiencing any of the following. If you have no symptoms in a category, please mark NONE.

GENERAL
○ sweats ○ weight loss
○ chills ○ appetite loss
○ fevers ○ fatigue (always tired) ○ NONE

EYES
○ blurring
○ vision loss (1 eye) ○ discharge
○ vision loss (both eyes) ○ eye irritation ○ NONE

EARS / NOSE / THROAT
○ decreased hearing ○ difficulty swallowing ○ NONE

CARDIOVASCULAR
○ chest pain / discomfort ○ palpitations
○ racing / skipping heartbeats ○ weight gain
○ shortness of breath with exertion ○ blackouts / fainting
○ difficulty breathing while lying down ○ swelling of hands / feet ○ NONE

RESPIRATORY
○ shortness of breath ○ wheezing
○ cough ○ coughing up blood ○ NONE

please fold on dotted line

GASTROINTESTINAL
○ vomiting
○ diarrhea ○ nausea ○ NONE

GENITOURINARY
○ pain
○ urinary retention
○ frequent UTI (urinary tract infection) ○ NONE

MUSCULOSKELETAL
○ joint swelling ○ back pain
○ joint pain ○ arthritis
○ muscle aches ○ stiffness
○ muscle cramps ○ loss of strength
○ muscle weakness ○ gout ○ NONE

SKIN
○ dryness ○ psoriasis
○ suspicious lesions ○ changes in color of skin
○ poor wound healing ○ unusual hair distribution ○ NONE

Continued on next page...

REVIEW OF SYSTEMS continued

NEUROLOGIC	◯ headaches ◯ weakness ◯ numbness ◯ tingling ◯ poor balance ◯ seizures	◯ tremors ◯ disturbances in coordination ◯ visual disturbances ◯ falling down ◯ memory loss ◯ **NONE**
PSYCHIATRIC	◯ anxiety ◯ depression	◯ **NONE**
HEME / LYMPHATIC	◯ abnormal bruising	◯ **NONE**
ALLERGIC / IMMUNOLOGIC	◯ seasonal allergies ◯ persistent infections	◯ **NONE**

ALLERGIES

please fold on dotted line

◯ **I have no known medication allergies.**

Are you allergic to any of the following? (Please list any reactions that you have.)

Allergen:	Reaction:	Allergen:	Reaction:
◯ latex		◯ betadine / iodine	
◯ tape		◯ sulfa	
◯ contrast dye		◯ metal(s)	
◯ shellfish / seafood		◯ novocain	
◯ PCN (Penicillin)			

OTHER (please include reaction): _____

MEDICAL HISTORY

Please indicate if you have had any of the following conditions:

- ◯ Anemia
- ◯ Anesthesia Problems
- ◯ Arthritis
- ◯ Asthma
- ◯ Birth Defect
- ◯ Bleeding Disease
- ◯ HIV
- ◯ Kidney Disease
- ◯ Liver Cancer
- ◯ Lung Cancer
- ◯ Lupus
- ◯ Mitral Valve Prolapse

please fold on dotted line

- ◯ Blood Clots
- ◯ Breast Cancer
- ◯ Bruise Easily
- ◯ Colon / Rectal Cancer
- ◯ COPD / Emphysema
- ◯ Depression
- ◯ Diabetes
- ◯ Fibromyalgia
- ◯ Heartburn
- ◯ Heart Attack
- ◯ Heart Disease
- ◯ Hepatitis A
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ High Blood Pressure
- ◯ MRSA
- ◯ Neuropathy
- ◯ Osteoporosis
- ◯ Polio
- ◯ Prostate Cancer
- ◯ Seizure Disorder
- ◯ STD (Sexually Transmitted Disease)
- ◯ Stomach Ulcers
- ◯ Stroke
- ◯ TB (Tuberculosis)
- ◯ Thyroid Disease
- ◯ **Other Cancer**
- ◯ **Other Connective Tissue Disorder**
- ◯ **Other Illness**
- ◯ **NO SIGNFICANT MEDICAL HISTORY**

SURGERIES

Please indicate if you have had any of the following surgeries:

- ◯ Adenoidectomy
- ◯ Appendectomy
- ◯ Cancer Surgery
- ◯ Carotid Artery
- ◯ Ear Tubes
- ◯ Gallbladder
- ◯ Gastric Bypass
- ◯ Heart Bypass
- ◯ Hernia
- ◯ Stomach Ulcer
- ◯ Thyroid
- ◯ Tonsillectomy

	Left	Right	Both
Kidney Removal	◯	◯	◯
Ovary Removal	◯	◯	◯
Breast Cancer Lump Removal	◯	◯	◯
Mastectomy	◯	◯	◯
Lung	◯	◯	◯
Foot	◯	◯	◯
Kyphoplasty	◯	◯	◯
Arthroscopic Shoulder	◯	◯	◯
Hip Fracture	◯	◯	◯
Total Hip Replacement	◯	◯	◯
Total Knee Replacement	◯	◯	◯
Arthroscopic Knee	◯	◯	◯
Total Shoulder Replacement	◯	◯	◯
Hand	◯	◯	◯

please fold on dotted line

OTHER (please specify):

_____

_____

_____

_____

_____

	TURP	Removal
Prostate	◯	◯

	Total	Partial
Colon Removal	◯	◯
Hysterectomy	◯	◯

	Single	Multiple
Vein Stripping	◯	◯
Leg Circulation	◯	◯

	Neck	Lower Back
Spinal Fusion	◯	◯

◯ **I have had NO SURGERIES**

FAMILY MEDICAL HISTORY

Please indicate which family members have had these conditions:

◯ **Family History UNKNOWN** ◯ **NONE**

please fold on dotted line

	Father	Mother	Brother	Sister
Diabetes	◯	◯	◯	◯
Lung Disease	◯	◯	◯	◯
Drug Abuse	◯	◯	◯	◯
Back Problem	◯	◯	◯	◯
Cancer	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯
Arthritis	◯	◯	◯	◯
Malignant Hypothermia	◯	◯	◯	◯
Depression	◯	◯	◯	◯
Osteoporosis	◯	◯	◯	◯
Stroke	◯	◯	◯	◯
High Blood Pressure	◯	◯	◯	◯

OTHER (please specify condition and family member): _____