GEORGIA BONE & JOINT SURGEONS, P.C.

PATIENT DEMOGRAPHICS

GEORGIA BONE & JOINT SURGEONS, P.C

PATIENT INFORMATION		
Patient's Last Name:	First:	Middle:
Street Address:		
City, State, Zip:	Email:	
Date of Birth:	SSN:	Gender: ☐ M ☐ F
Home Phone:	Cell Phone:	
Preferred Pharmacy:	Phone:	
Primary Physician:	Who Referred You To Our Office:	

EMERGENCY CONTACT	
Name:	Relationship to Patient:
Phone:	Address:

EMPLOYER INFORMATION	
Current Employer:	Phone:
Address:	

GUARANTOR INFORMATION		
Person Responsible For Bill (please leave blank if same as patient)		
Name:	Date of Birth:	Phone:
Address:		

INSURANCE INFORMATION (please leave blank if attaching insurance card)				
Primary Insurance Name:				
Subscriber's Name:	Policy #		Co-pay $	
Subscriber DOB: Subscriber SSN:	Group #		Group Name:	
Patient's Relationship to Subscriber	Self ( )	Child ( )	Spouse ( )	Other ( )
Secondary Insurance Name:				
Subscriber's Name:	Policy #		Co-pay $	
Subscriber DOB: Subscriber SSN:	Group #		Group Name:	
Patient's Relationship to Subscriber	Self ( )	Child ( )	Spouse ( )	Other ( )

Patient Signature Date Legal Guardian / Relationship to Patient Date

GEORGIA BONE & JOINT SURGEONS, P.C.

INTAKE AND CONSENT

GEORGIA BONE & JOINT SURGEONS, P.C

Date:	Patient Name:	Acct: (office only)
1. Please describe injury or problem for which you are being seen today. Include "right" or "left" if applicable:		Date symptoms first occurred:
2. Have you been treated previously for this injury / problem:	Yes ☐ No ☐	When:

Doctor's Name / Facility:

Please describe treatment:

Were X-Rays taken?	Yes ☐	No ☐	If yes, do you have a copy with you today?	Yes ☐	No ☐

3. Is condition the result of injury / accident?

☐ Work ☐ Place of Business
☐ Home ☐ School
☐ Auto State:

Other:

Brief description of how injury occurred:

4. Is there any insurance, liability coverage, or third party responsible (other than your own group health insurance) for payment of treatment related to this injury / accident / condition: Yes ☐ No ☐

5. Do you have an attorney for this accident: Yes ☐ No ☐

Attorney Name____________________________ Attorney Phone ____________________________

6. AUTHORIZATION FOR TREATMENT ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I authorize Georgia Bone & Joint Surgeons, P.C./Center For Orthopedic Surgery/Center for Physical Therapy and Sports Medicine and providers thereof, to render treatment and to release any medical information (including information related to psychiatric care, drug/alcohol abuse, and HIV/AIDS) necessary to process claims, for any utilization review or quality assurance activities, or if and when applicable, as requested by subpoena, request for production of documents, or other court order, whether released verbally, written, or by fax. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled for this or any other claim filed related to treatment received at Georgia Bone & Joint Surgeons, P.C, Center for Orthopedic Surgery/Center for Physical Therapy and Sports Medicine. This assignment and authorization shall remain in effect unless revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that, even though I may have some type of insurance coverage, I am responsible for payment of services. I further understand that as the person authorizing treatment for a minor child, I am responsible for the charges incurred regardless of other agreements in place. By signing below, I am affirming that I have completed this form fully and that the information furnished is correct to the best of my knowledge. I am also affirming that I have read and understand the contents of the authorization above and my responsibilities therein. If I am insured by Medicare, I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier, any information needed for this or a related Medicare claim whether verbal, written, or by fax. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply. I also verify that I have received a copy of the Notice of Privacy Practices.

Patient Signature Date Legal Guardian / Relationship to Patient Date

GEORGIA
BONE & JOINT
SURGEONS, P.C.

PRESCRIPTION INFORMATION

GEORGIA BONE & JOINT SURGEONS, P.C

Important Information Regarding Prescription Refills

Effective 10/6/2014, hydrocodone pain medications can no longer be phoned in to the pharmacy. The DEA has changed the classification of the drug to Schedule Il which means it must be a written, signed prescription. <u>No hydrocodone pain medication products will be able to be called in, refilled electronically, or faxed after 1013/2014.</u>

1. As a general rule, the doctors will be unable to prescribe Class Il pain medications unless a patient has had (or will be having) orthopedic surgery or has a serious fracture (broken bone). This includes hydrocodone or any product that contains hydrocodone.
2. The doctors will be unable to prescribe any medications for patients after hours, on the weekend, holidays, or any other time the office is closed.
3. Due to the changes, you may experience a delay in obtaining a pain medication refill as they can only be processed on days the physician is seeing patients in the office. Accordingly, please call at least 3 business days ahead of needing a refill.
4. The patient (if age 18 or older), must call personally to request the refill or be available by phone to confirm the request.
5. Prescription refill request hours are Monday-Thursday 8am-5pm. Please call 770-386-5221 during these office hours for refills. If the refill requires a written prescription, someone from our office will call you when it is ready to pick up.
6. Written prescriptions may be picked up during regular office hours Monday-Thursday 8am-5pm and Friday 8am-Noon.
7. Anyone (including patient) picking up a prescription must show picture ID and sign for the prescription.
8. If anyone other than the patient is picking up the prescription, they must be on the contact list in the patient's medical record. Prescriptions will not be released to anyone not listed in the patient's medical record.
9. Anyone prescribed narcotic pain medications may be subject to drug testing (at the patient's expense) or other pain management monitoring and compliance measures that are required by state or federal regulations.
10. A follow-up visit may be required in order to obtain a refill.
11. The doctors will not refill prescriptions that have been lost, stolen, or misplaced.
12. Giving, trading, or selling medications is grounds for immediate dismissal.
13. Obtaining narcotics from any other physician without notifying Georgia Bone & Joint Surgeons is grounds for immediate dismissal.
14. Altering or forging of a prescription is a felony and will be reported.
15. Medication history, if available, will be verified electronically for inclusion in the medical record.

We thank you for your cooperation and assistance in adhering to the new regulations. Please sign below indicating that you have read and understand the above.

Patient Signature Date Legal Guardian / Relationship to Patient Date

GEORGIA BONE & JOINT SURGEONS, P.C.

REVIEW OF SYSTEMS Part 1 of 2

GEORGIA BONE & JOINT SURGEONS, P.C

Office Use Only

Date:	Patient Acct:	BP	Pulse	Ht	Wt

To Be Completed By Patient

Patient Name:	Date Of Birth:
Reason For Your Visit Today:	Date Problem Began:
Primary Care Physician:	Referred By:

Your Allergies

1. Are you allergic to any medications? ☐Yes ☐No
2. If yes, please list:
3. List any other allergies:

Your Medications

1. Do you currently take any blood thinners? ☐Yes ☐No
2. List all current medications including dosage and how often taken

Your Past Surgical History

1. Please list any surgeries you have had and date of surgery:
2. Do you have any implants or metal of any type? ☐Yes ☐No
3. If yes, type:

Your Past Medical History

1. Please circle if you have / have had any of the following:

If NONE, initial here:

☐Lung Disease ☐Heart Disease ☐Heart Attack ☐High Blood Pressure
☐A-Fib ☐Seizures ☐Diabetes ☐Hepatitis ☐Liver Disease ☐Rheumatoid Arthritis
☐Osteoarthritis ☐Anemia ☐Blood Clots ☐HIV/AIDS ☐Kidney Disease ☐Psychiatric Disorder
☐Stroke ☐Pacemaker ☐Parkinson's Disease ☐Stomach Ulcer ☐Cancer ________________________________
☐Dementia ☐Asthma ☐Hyperthyroid ☐Hypothyroid ☐Anesthesia Reaction

Your Past Family History

1. Please circle if there is any family history of:

If NONE, initial here:

☐Lung Disease ☐Heart Attack ☐Pacemaker ☐High Blood Pressure
☐Diabetes ☐Stomach Ulcer ☐Hepatits ☐Liver Disease ☐Anemia ☐Psychiatric Disorder
☐Blood Clots ☐HIV/AIDS ☐Kidney Disease ☐Seizures ☐Stroke ☐Rheumatoid Arthritis
Cancer________________________ ☐Anesthesia Reaction ☐Asthma ☐Hyperthyroid ☐Hypothyroid

1. Occupation:
2. Marital Status: ○Married ○Single ○Divorced ○Widowed
3. Are You: ○Right Handed ○Left Handed

Your Social History

1. Do you currently smoke? ○Yes No○
2. If yes, number of packs per day ______
3. Year quit if former smoker____________
4. Do you use smokeless tobacco? Yes No

5. Do you use alcohol? ○Yes ○No
6. If yes, how much, how often:
____
____

7. Any history of drug abuse? ○Yes ○No
8. If yes, type of drug?
9. Any current drug abuse? ○Yes ○No
10. If yes, type of drug?

1. Has anyone ever told you that you have diminished kidney function?	○Yes	○No
2. If required during surgery, would you object to receiving a blood transfusion?	○Yes	○No
3. Have you had a flu vaccine within the last 12 months?	○Yes	○No
4. Are you currently under the care of Pain Management?	○Yes	○No

REVIEW OF SYSTEMS Part 2 of 2

GEORGIA BONE & JOINT SURGEONS, P.C

1. Please circle if you are currently having any of the following symptoms or conditions: Circle all that apply

If you are not currently having any of the symptoms below, please initial here:________________

General	Head	Eyes	Ears	Nose	Neck	Psych
☐ Fever ☐ Chills ☐ Night Sweats ☐ Fatigue ☐ Weight Gain ☐ Weight Loss ☐ Loss of Appetite	☐ Headache ☐ Dizziness	☐ Vision changes ☐ Pain ☐ Double vision ☐ Blurred vision	☐ Earache ☐ Discharge ☐ Decreased hearing ☐ Ringing ☐ Deafness	☐ Bleeding ☐ Discharge ☐ Sinus ☐ Pain	☐ Pain	☐ Anxiety ☐ Depression ☐ Insomnia ☐ Agitation ☐ Hallucinations ☐ Disorientation

Mouth & Throat	Nodes	Breasts	Respiratory	Cardiac	Skin
☐ Sore Throat ☐ Sores Bleeding ☐ Gums ☐ Hoarseness	☐ Enlargement ☐ Tenderness	☐ Lumps ☐ Pain	☐ Cough ☐ Wheezing ☐ Bloody Sputum ☐ Shortness of breath ☐ Congestion ☐ Chest Pain	☐ Chest Pain ☐ Palpitations ☐ Swelling ☐ Sweating ☐ Shortness of breath ☐ Chest discomfort	☐ Glands swelling ☐ Rashes ☐ Leg ulcer ☐ Itching

Urinary (GU)	Blood Disorders	Musculoskeletal	Gastrointestinal (GI)	GYN	Neurological
☐ Painful urination ☐ Burning ☐ Blood in urine ☐ Frequency ☐ Urine leaking ☐ Hesitancy ☐ Nighttime urination ☐ Incomplete emptying of bladder ☐ Testicular masses	☐ Anemia ☐ Bruising ☐ Easy bleeding	☐ Back pain ☐ Radiating pain ☐ Joint pain ☐ Joint swelling ☐ Injury ☐ Muscle aches ☐ Bone pain	☐ Difficulty swallowing ☐ Heartburn ☐ Nausea/Vomiting ☐ Abdominal pain ☐ Swelling ☐ Diarrhea ☐ Constipation ☐ Blood in stool ☐ Hemorrhoids ☐ Jaundice	☐ Excessive menstrual bleeding ☐ Irregular periods ☐ Hot flashes ☐ Discharge ☐ Post menopausal bleeding	☐ Memory loss ☐ Confusion ☐ Weakness ☐ Dizziness ☐ Tremors ☐ Numbness ☐ Paralysis

Completed By Office
Reviewed by Provider: ________________________________ **Date**:_____________________

SPINE PATIENT ENCOUNTER FORM

NAME:______________________________ DOB:______________ DATE:________________

1\. WHAT KIND OF PAIN ARE YOU HAVING? (CHECK ALL THAT APPLY) | PLEASE DESCRIBE THE TYPE OF PAIN YOU ARE HAVING. (CHECK ALL THAT APPLY) | RATE SEVERITY FROM 1 TO 10 WITH 10 BEING THE WORST PAIN. (CIRCLE)

	Sharp	Dull	Aching	Stabbing	Throbbing	Severity
☐ BACK PAIN	☐	☐	☐	☐	☐	1 2 3 4 5 6 7 8 9 10
☐ NECK PAIN	☐	☐	☐	☐	☐	1 2 3 4 5 6 7 8 9 10
☐ LEFT LEG PAIN	☐	☐	☐	☐	☐	1 2 3 4 5 6 7 8 9 10
☐ RIGHT LEG PAIN	☐	☐	☐	☐	☐	1 2 3 4 5 6 7 8 9 10
☐ LEFT ARM PAIN	☐	☐	☐	☐	☐	1 2 3 4 5 6 7 8 9 10
☐ RIGHT ARM PAIN	☐	☐	☐	☐	☐	1 2 3 4 5 6 7 8 9 10

2\. HOW LONG HAVE YOU BEEN HAVING PAIN? ____DAYS ____WEEKS ____MONTHS ____YEARS

3\.

WHAT IS THE RATIO OF BACK TO LEG PAIN?	WHAT IS THE RATIO OF NECK TO ARM PAIN?
☐ 100% BACK/ 0% LEG PAIN	☐ 100% NECK/ 0% ARM PAIN
☐ 75% BACK/ 25% LEG	☐ 75% NECK/ 25% ARM PAIN
☐ 50% BACK/ 50% LEG PAIN	☐ 50% NECK/ 50% ARM PAIN
☐ 25% BACK/ 75% LEG PAIN	☐ 25% NECK/ 75% ARM PAIN
☐ 0% BACK/ 100% LEG PAIN	☐ 0% NECK/ 100% ARM PAIN
☐ NO BACK/LEG PAIN	☐ NO NECK/ ARM PAIN

4\. ARE YOUR SYMPTOMS DUE TO AN INJURY? ☐ YES ☐ NO
IF THE ANSWER IS YES, PLEASE GIVE DATE AND EXPLAIN THE DETAILS REGARDING THE INJURY:

____

____

____

5\. IF YOU ARE SUFFERING FROM BACK OR NECK PAIN, WHAT PERCENTAGE OF THE PAIN IS RELIEVED WHEN LYING DOWN IN YOUR MOST COMFORTABLE POSITION?

- ☐ 100% RELIEF WHEN LYING DOWN
- ☐ 75% RELIEF WHEN LYING DOWN
- ☐ 50% RELIEF WHEN LYING DOWN
- ☐ 25% RELIEF WHEN LYING DOWN
- ☐ 0% RELIEF WHEN LYING DOWN

6\. WHAT POSITIONS AGGRAVATE YOUR SYMPTOMS? (CHECK ALL THAT APPLY)

- ☐ STANDING
- ☐ WALKING
- ☐ SITTING
- ☐ FORWARD BENDING
- ☐ BACKWARD BENDING
- ☐ SIDE BENDING
- ☐ GETTING OUT OF BED

7\. PLEASE DESCRIBE YOUR WALKING TOLERANCE:

- ☐ I CAN WALK INDEFINITELY.
- ☐ I CAN WALK UP TO AN HOUR.
- ☐ I CAN WALK UP TO 30 MINUTES.
- ☐ I CAN WALK UP TO 15 MINUTES.
- ☐ I CAN WALK LESS THAN 5 MINUTES

8. HAVE YOU NOTICED ANY OF THE FOLLOWING SYMPTOMS? (CHECK ALL THAT APPLY)

- ❑ CLUMSINESS
- ❑ DROPPING OBJECTS MORE FREQUENTLY
- ❑ WORSENING HANDWRITING
- ❑ UNSTEADY WHEN WALKING
- ❑ NONE OF THE ABOVE

9. HAVE YOU NOTICED ANY CHANGE IN YOUR BODY SHAPE RECENTLY? ❑ YES ❑ NO
IF YES, THEN OVER WHAT TIME PERIOD? ____________________

10. WHAT TREATMENTS HAVE YOU HAD FOR YOUR CURRENT SYMPTOMS? (CHECK ALL THAT APPLY)

	DID THE TREATMENT HELP?
❑ HOME EXERCISE PROGRAM	❑ YES ❑ NO
❑ PHYSICAL THERAPY	❑ YES ❑ NO
❑ EPIDURAL STEROID INJECTIONS	❑ YES ❑ NO
❑ FACET BLOCKS	❑ YES ❑ NO
❑ NSAIDS (MOTRIN, IBUPROFIN, CELBREX, BEXTRA, VIOXX, LODINE, ETC.)	❑ YES ❑ NO
❑ NARCOTICS (LORTAB, DARVOCET, VICODIN, PERCOCET, OXYCONTIN, ETC.)	❑ YES ❑ NO
❑ ULTRA / ULTRACET	❑ YES ❑ NO
❑ CHIROPRACTOR MANIPULATION	❑ YES ❑ NO
❑ BRACES	❑ YES ❑ NO
❑ WEIGHT REDUCTION PROGRAM	❑ YES ❑ NO

11. HAVE YOU MODIFIED ANY ACTIVITIES? ❑ YES ❑ NO

12. HAVE YOU HAD ANY PREVIOUS SPINE SURGERIES? ❑ YES ❑ NO
IF YES, PLEASE LIST THE NAME OF THE PROCEDURE, THE DATE AND THE SURGEON:

____

____

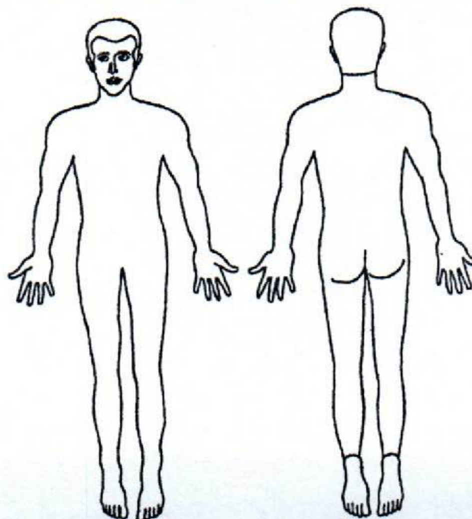
13. HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS? (CHECK ALL THAT APPLY)

- ❑ FEVERS
- ❑ CHILLS
- ❑ NIGHT SWEATS
- ❑ WEIGHT LOSS
- ❑ NONE OF THE ABOVE

14. DOES THE PAIN WAKE YOU UP FROM SLEEP AT NIGHT? ❑ YES ❑ NO

15. HAVE YOU EVER LOST BOWEL OR BLADDER CONTROL? ❑ YES ❑ NO

16. PLEASE SHADE IN THE AREAS ON THE DIAGRAMS THAT CORRESPOND TO YOUR AREAS OF PAIN ON YOUR BODY.



NAME:____________________________ **DOB:**____________ **Acct#**____________ **DATE:**__________

Age:________yrs **Sex:** Male Female **CC:**________________________ **Duration or DOI**____________

HPI: Precipitating event (trauma, gradual, work injury, other). List any spinal surgeries

- ☐ MRI
- ☐ HOME EXERCISE PROGRAM
- ☐ PHYSICAL THERAPY
- ☐ INJECTIONS
- ☐ FACET BLOCKS
- ☐ NSAIDS
- ☐ NARCOTICS
- ☐ CHIROPRACTIC MANIPULATION
- ☐ BRACES
- ☐ WEIGHT REDUCTION PROGRAM

PMH/PSH:

Nicotine:
Allergies:

PHYSICAL EXAM:

Vitals (At least 3 items)

Height	
Weight	
Temp	
Pulse	
RR	
BP	

Appearance:
Well Groomed / Disheveled
Other________

Orientation:
A+OX4
Other________

Mood/Affect:
Normal / Depressed
Tearful / Histrionic
Other________

Pulses

	R	L
DP		
PT		
Radial		
Ulna		

The four limbs
(Circle Nl or Crossout and write in below)

	RU	LU	RL	LL
Inspection	Nl	Nl	Nl	Nl
Skin	Nl	Nl	Nl	Nl
ROM	Nl	Nl	Nl	Nl
Stability	Nl	Nl	Nl	Nl
Muscle Tone	Nl	Nl	Nl	Nl
Edema	Nl	Nl	Nl	Nl

Abnormal Limb Findings

Spine (Circle or fill in blank)
Coronal Balance:__________
Sagittal Balance:__________
Shoulders: Level
Ribs: __________
Pelvis: Level or __________

Scars

TTP

Lymphadenopathy:
Neck No Yes
Axila No Yes
Groin No Yes

Coordination
Gait: Nl, Antalgic, Other__________
Dysdiadokinesia: Nl Abnl

ROM

	Cer	Tho	Lum
FF			
Ext			
Rt Bend			
Left Bend			
Rt Rot			
Left Rot			

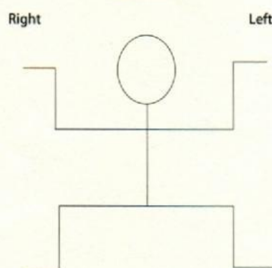
Comments:

Sensory changes:

Motor

	Right	Left
Deltoid		
Biceps		
Triceps		
Wrist Flex		
Wrist Ext		
Grip		
Intrinsics		
IP		
Quad		
HS		
TA		
EHL		
GS		

DTR



Myelopathic Signs

	Right	Left
Hoffman		
IBR		
L'hermitte		
Clonus		
Babinski		

Radicular Signs

	Right	Left
SLR		
FS		
Spurling		
Abduction		

DATA

Circle the test and indicate ordered or reviewed (O=Ordered. R=Reviewed)

Clinical lab	Medical diagnostics	Old records or Additional Hv Not from Patient
CBC Chem Other	EKG PFT Other	Old records Hx from family

Data

Ordered or reviewed	Points	Score
Clinical Lab	1	
Radiology	1	
Med Dx	1	
Decision to obtain old records or hx from source to supplement pt	1	
Direct visualization of image or interp of test	1 per test	
Review and dictate old record	2	

Total score= 1=Min 2=Limited 3=Mod 4=Extensive

Imaging Studies:

☐ Radiology Ordered Today (X-Ray, MRI, CT-Scan)

X-Ray

#Dx or Mgt Options

	Points	Score
# of new or chronic self-limiting or minor problems	if 1 ->1 if >1 ->2	
Presenting prob Estab Dx a) Improved, well controlled, resolving, or resolved	______# Mult X 1	
b) Inadequately controlled, worsening, failure to change	_____# Mult X2	
New prob, no additional w/u planned. (additional new prob no credit)	3	
New problem, additional w/u planned (additional new prob no credit)	4	

Total score = 1=Min 2=Limited 3=Multiple 4=Extensive

MRI/CT

Risk

High Risk: Chronic illness with severe exacerbation. Pt needs Major surgery w/risk factors. Abrupt neuro change. Or ordering discography. Emergency Major Surgery

Moderate Risk: Chronic illness with mild exacerbation. Two or more stable chronic illnesses. New problem with uncertain prognosis. Ordering stress test (DSE). Pt needs elective major surgery w no risk factors. Minor surgery with risk factors. Drug prescription.

Low Risk: >1 self-limited or minor problems. 1 stable chronic illness. PFT. Needle Bx. OTC drugs. Minor surgery without risk factor. PT. OT.

Minimal Risk: 1 self-limited or minor problem. Venipuncture lab test. CXR. UA. Echocardiogram.

Diagnosis:

Recomendation/Plan:

MDM

Risk	Data	Dx/Mgt	MDM
Min	1	1	Stfwd
Low	2	2	Low
Mod	3	3	Mod
Hi	4	4	High

Chose lower of the top 2

The amount/complexity of data reviewed /ordered is__________.
Pt. has _______level of risk as determined by AMA/HCFA guidelines because...
The number of diagnosis or management options are___________.
Therefore, the complexity of the MDM is___________________.

Signature:______________________________ Date__________________