GEORGIA BONE & JOINT SURGEONS, P.C.
Your Bones. Our Business.

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

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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

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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. No hydrocodone pain medication products will be able to be called in, refilled electronically, or faxed after 1013/2014.

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

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**:_____