# PATIENT DEMOGRAPHICS FORM

## *PATIENT INFORMATION*

Patient's Last Name: | First: | Middle:

Street Address:

City, State, Zip:

Home Phone: ______________________
May we leave a voicemail message? ❑ Yes ❑ No
If yes, select type of message: ❑ Brief ❑ Extended

Cell Phone: ______________________
May we leave a voicemail message? ❑ Yes ❑ No
If yes, select type of message: ❑ Brief ❑ Extended

Date of Birth: | Gender: ❑ Male ❑ Female

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated | SSN:

Email Address: | Preferred Language: ❑ English ❑Spanish ❑ Other

Who is your family doctor? First/Last Name/City | Who referred you to Pinnacle? First/Last Name/City

Race: (Select one)
❑American Indian or Alaska Native ❑ Asian ❑ Black or African American
❑ Hispanic ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other Race

Ethnicity: (Select one)
❑ Hispanic or Latino
❑ Not Hispanic or Latino

Please complete if covered under Worker's Comp:
Employer Name: | Address:
Phone Number:

## *INSURANCE INFORMATION*

Person Responsible for Bill: | Birth Date: | Home Phone:

Address (if different):

**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

## *IN CASE OF EMERGENCY*

Name of Friend or Relative: | Relationship to Patient: | Contact Number:

## *PREFERRED PHARMACY*

Name: ______________________
Address: | Phone: | Fax:

Initial: ______________

# PINNACLE ORTHOPAEDICS & SPORTS MEDICINE SPECIALISTS, L.L.C.
## PATIENT ACKNOWLEDGMENT (continued)

**Patient Name**_______________________________________________ **DOB:** _______________

### RECEIPT OF NOTICE OF PRIVACY PRACTICES & RELEASE AUTHORIZATION FORM

I authorize Pinnacle Orthopaedics & Sports Medicine, LLC to use and/or disclose the Protected Health Information (''PHI'' or personal medical records) described below to: **(Note: this includes releasing prescriptions, medical forms, etc.)**

Name ______________________________ Relationship _______________ Phone ______________________
Name ______________________________ Relationship _______________ Phone ______________________
Name ______________________________ Relationship _______________ Phone ______________________

**Authorization for release of your personal medical record information covering the period of health care.**

**(Select One)** ☐ All of my medical records "PHI" Past, Present and Future Periods OR
☐ From (Date) _________________ to (Date)_______________________.

**I hereby authorize the release of my personal medical information as follows:**

**(Select One)**

☐ a. My complete health record "PHI" (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR

☐ b. My complete health record "PHI" *with the exception of the following information* **(circle as appropriate):**

Mental health records — Communicable diseases (including HIV and AIDS)
Alcohol/drug abuse treatment — Other (please specify): _______________________

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until nine (9) months after my death or _______________, (Date) at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices on the date indicated and authorize the release of PHI as described above.

**(Continued on next page)**

Initial: __________________

# PINNACLE ORTHOPAEDICS & SPORTS MEDICINE SPECIALISTS, L.L.C.
## PATIENT ACKNOWLEDGMENT (continued)

**Patient Name**_____________________________________________________________ **DOB:** ______________________

## Text Messaging and Emailing Patient Information

We offer helpful administrative information by regular text messaging and email, like appointment reminders, medical records request from patient, completed medical forms, etc. There is **some level of risk** that information in a regular text message or email could be read by someone besides you. Please review both questions:

**1)** ☐ **Yes** – Please communicate with me by email, I understand it is my responsibility to make Pinnacle aware if my email address changes.

☐ **No** – Please do not communicate with me by regular (unencrypted) email.

**2)** ☐ **Yes** – Please communicate with me by text message, I understand it is my responsibility to make Pinnacle aware if my cell phone number changes.

☐ **No** – Please do not communicate with me via text messaging.

### 24 Hour Cancellation and "No Show" Administrative Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care or diagnostic testing. Therefore, Effective July 15, 2014, Pinnacle Orthopaedics reserves the right to charge a fee for missed appointments ("no shows") and appointments not cancelled with a 24-hour advance notice.

***The following fees will be assessed for no-shows and late cancellations:***

| | |
|---|---|
| Physical Therapy | $ 25.00 |
| MRI and/or Arthrogram | $150.00 |
| Office Visits | $ 25.00 |
| EMG/NCS Test | $ 75.00 |
| Injections/Epidurals within 48-hour notice | $150.00 |
| Surgeries within 48 Hour Notice | $500.00 |

"No Show" and late cancellation fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" and late cancellations in any 12-month period may result in termination from our practice.

**(Continued on next page)**

Initial: ___________________

# PINNACLE ORTHOPAEDICS & SPORTS MEDICINE SPECIALISTS, L.L.C.

## PATIENT ACKNOWLEDGMENT

**Patient Name**_________________________________________________________________ **DOB:** _______________

**PAYMENT RESPONSIBILITY**

Payment for services or the co-payment and/or the co-insurance is payable when service is rendered. Payment for medical services is between Pinnacle Orthopaedics and the patient/responsible party. Therefore, Pinnacle Orthopaedics cannot accept responsibility for collecting or negotiation settlement on any disputed (1) health insurance claim, (2) worker's compensation claim, (3) accidental injury/illness liability claim, (4) claim where patient is or will be represented by an attorney, and/or (5) claim to be settled in a court of law.

Most insurance carriers require a written referral form from a Primary Care Physician in advance of service provided by Pinnacle Orthopaedics. Patients or person responsible for the patient must (1) obtain physician referrals and (2) contact the insurance carrier to verify benefits in advance of service. At the time of service, patients are responsible for payment for non-covered services, deductibles and co-insurance. Patients are also responsible for any penalties imposed by their insurance company for seeing the patient out-of-network. Pinnacle Orthopaedics will file a patient's insurance as a courtesy.

The patient or responsible party certifies that information provided relative to injury, illness, and insurance coverage is both true and correct. By signing this form, the patient or responsible party authorizes payment of insurance benefits or proceeds from any liability claim or legal or court settlement to be assigned to Pinnacle Orthopaedics to the extent that their charges are paid in full.

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I authorize the physician to release any record, x-rays, and photographs acquired in the course of my treatment to referring physicians, insurance companies, hospitals or surgery centers. I authorize the release of all information necessary to transmit and process claims electronically and/or through any other reasonable and customary means in order to secure payment.

**PHYSICIAN ASSISTANTS**

Pinnacle Orthopaedics utilizes Physician Assistants in our offices. Physician Assistants may provide care for you during your office visit. By signing this form, you give permission to have Physician Assistants assist in your care.

**CONSENT TO TREAT**

I hereby volunteer consent to my treatment at Pinnacle Orthopaedics and authorize such treatments, examinations, physical therapy and diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered by my attending /covering physician.

**E-PRESCRIBING**

Pinnacle Orthopaedics providers utilize e-Prescribing to electronically send an accurate, error free and understandable prescription directly to a pharmacy. By signing below, you are providing your consent for the pharmacy e-Prescription program.

**(Continued on next page)**

Initial: __________________

**PINNACLE ORTHOPAEDICS & SPORTS MEDICINE SPECIALISTS, L.L.C.**
**PATIENT ACKNOWLEDGMENT (continued)**

**Patient Name:** _______________________________________________ **DOB:** _________________

## Pinnacle HealthShare Exchange (HSX) Patient Consent Form

Health Information Exchange (HIE) is the electronic sharing of health information between participating healthcare providers in a way that ensures the secure exchange of health information to provide care to patients.

Pinnacle Orthopaedics participates in a Health Information Exchange program. Please choose if you would like to Opt Out. If you choose to Opt Out, health information about you will NOT be accessible to healthcare providers and other authorized users through the HIE. HSX participants who search for information about you will receive a message informing them that you Opted Out.

This request does not prohibit your healthcare provider from otherwise disclosing your medical information based on other authorizations and applicable law, or by other methods.

Please select only if you choose to Opt Out: ☐

## Were You Referred By a School or Team?

Please **CIRCLE** one of the following if you were referred by or attend the follow schools or teams:

| | | | |
|---|---|---|---|
| Allatoona HS | Hillgrove HS | KSU Varsity Sports | Thunder/LB 3 Lacrosse |
| Atlanta Blaze | Harrison HS | Lassister HS | Walker HS |
| Atlanta Storm Lacrosse | Kell HS | Life Univ | Walton HS |
| Cherokee County Schools | Kennesaw Mtn HS | North Cobb HS | Westminster HS |
| Cobb Atlanta Volleyball | KSU Club Sports | Sequoyah HS | |

## Signature Page

By signing this form, I verify that I am the person named above, or I am legally authorized to complete this form for the person named above. I have read and completed all five forms and the information provided on these forms, and the preferences expressed herein, are accurate to the best of my abilities.

_______________________________________ ____________________
Signature of Patient/Legal Guardian Date

_______________________________________ ____________________
Print Name of Legal Guardian Relationship to Patient

# New Patient Information Form

Please darken bubbles completely

| PATIENT INFORMATION | | |
|---|---|---|
| **Patient Name:** | **DOB:** | **Date:** |

**What are you being seen for today?**

O Neck O Right Shoulder O Left Shoulder O Right Elbow/Arm O Left Elbow/Arm
O Mid Back O Right Wrist O Left Wrist O Right Hand O Left Hand
O Low back O Right Hip/Thigh O Left Hip/Thigh O Right Knee O Left Knee
O Ribs O Right Calf/Leg O Left Calf/Leg O Right Ankle O Left Ankle
O Right Foot O Left Foot Other:___________________________________

**How long have symptoms been present or date of injury:** ___________________________________________

**How did the pain occur?** O Injury O Ongoing Problem O Spontaneous

**Is this the result of a motor vehicle accident?** O Yes O No

**Is this work related?** O Yes O No **What is your occupation?** __________________________________________

**Height:** __________ **Weight:** _________ **Are you?** O Right-Handed O Left-Handed **(Female) Pregnant:** O Yes O No

**Are you taking any Medications for this problem? (Please list medications in detail below)**

O - Narcotic (Vicodin, Codeine, etc.) O - Anti-Inflammatory (Advil, Motrin, etc.) O - Muscle Relaxer (Flexeril, Soma, etc.)

**Have you received injections for this problem?** O Yes O No **If yes, when?** ___________________________

| **Medications: (Please list below the names of medication you are taking and the dosage) or Check if List Provided** ☐ | | |
|---|---|---|
| | | |
| | | |
| | | |
| **Allergies: (Please list the medications you are allergic to)** | | |
| | | |
| **Surgeries and Procedures: (Please list the type of surgery or procedure and year)** | | |
| | | |
| | | |
| **Hospitalizations: (Please list what you were hospitalized for NOT REQUIRING SURGERY and the approximate date)** | | |
| | | |
| | | |

**What is the quality of your pain?** O Mild O Moderate O Severe

**How would you describe your pain?** O Sharp O Dull O Burning

**What makes your symptoms worse?** O Standing O Walking O Lifting O Exercise O Twisting O Lying in Bed O Bending O Squatting O Kneeling O Stairs O Sitting O Sleeping

**What makes your symptoms better?** O Rest O Elevation O Ice O Heat

**Do you have numbness/tingling?** O Yes O No **Do you have any weakness?** O Yes O No

**Have you had physical/occupational therapy?** O Yes O No

**If yes, where and date range?** __________________________________________________

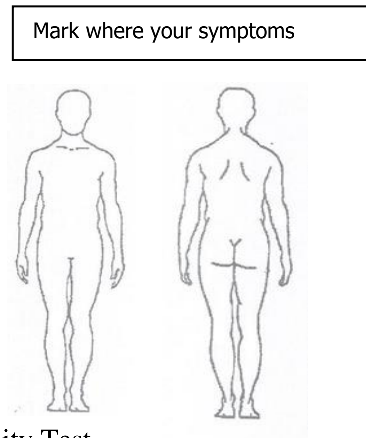
**Have you been treated elsewhere for this problem?** O Yes O No

**If yes, where and by whom?** ____________________________________________________

**Pain Scale:** On a scale of 0 to 10 (0 meaning no pain and 10 meaning worst pain), how would you rate the pain you are currently experiencing?

O 0/10 O 1/10 O 2/10 O 3/10 O 4/10 O 5/10
O 6/10 O 7/10 O 8/10 O 9/10 O 10/10

Mark where your symptoms



**Have you had any of the following diagnostic tests for this problem?**

O X-Ray O MRI O EMG/NCS O Bone Scan O CT Scan O CT myelogram O Bone Density Test

**Do you have any metal in your body?** O Yes O No **If yes, where?** ______________________________________

**Have you ever broken a bone from a simple fall or without trauma?** O Yes O No

**Do you use the following?** O Cane O Walker O Wheelchair

**Patient Name:** ______________________________________________________ **DOB:** ________________________

## Medical History

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| O | Osteoporosis | O | High Blood Pressure | O | Diabetes | O | Thyroid Disease |
| O | Arthritis | O | Heart Disease | O | Cancer | O | DVT/Pulmonary Embolism |
| O | Poor Circulation | O | Irregular Heart Beat | O | Anemia | O | Asthma |
| O | Epilepsy/Seizures | O | Heart Attack | O | Kidney Disease | O | Emphysema/COPD |
| O | Stroke | Other:_______________________________________________________________ | | | | | |

## Infectious Diseases

O Tuberculosis O Lyme Disease O Hepatitis O MRSA

**Please list other infectious diseases you have been diagnosed with**: ___________________________________________

## Social History

**Do you have an Advance Directive (Living Will)?** O Yes O No **If yes, please give a copy to the front desk to scan in your chart.**

**Do you use tobacco/nicotine products?** O Yes O No **If no, have you use tobacco/nicotine in the past?** O Yes O No

**Do you drink alcohol?** O Yes O No **If yes, how many times per day?** O 1 or less O 2-3 O 3 or more

**Do you exercise regularly?** O Yes O No **If yes, how often?** O 2-3 times/ week O 5+ times/week

**Do you participate in sports/recreational activities?** O Yes O No **If Yes, what activities?** ______________________

## Family History

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Mother | O | Cancer | O | Osteoporosis | O | DVT/Pulmonary Embolism | O | Arthritis |
| Father | O | Cancer | O | Osteoporosis | O | DVT/Pulmonary Embolism | O | Arthritis |
| Siblings | O | Cancer | O | Osteoporosis | O | DVT/Pulmonary Embolism | O | Arthritis |

## Review of Systems: Are you experiencing any of these issues now?

### General
O **Denies All** O Fatigue O Fever/Chills O Weight Change O Environmental Allergies O Problems w/ Anesthesia

### Eyes/Ears
O **Denies All** O Glasses/Contacts O Eye Pain O Cataracts O Hearing Aids O Ringing/Buzzing O Ear/Eye Infection

### Neurological
O **Denies All** O Fainting O Numbness/Tingling O Weakness O Headaches O Dizziness O Blurred/Double Vision

### Respiratory
O **Denies All** O Wheezing O Chronic Coughing O Shortness of Breath

### Cardiovascular
O **Denies All** O Chest Pain O Heart Murmur O Phlebitis O Swelling of feet

### Musculoskeletal
O **Denies All** O Joint Pain/Swelling O Joint Stiffness O Muscle Pain O Back Pain

### Gastrointestinal
O **Denies All** O Heartburn O Nausea/Vomiting O Constipation O Diarrhea O Ulcers

### Skin
O **Denies All** O Rashes/Sores O Itching/Burning

### Genitourinary
O **Denies All** O Painful Urination O Frequent Urination O Blood in Urine

### Hematological
O **Denies All** O Easy Bruising O Bleeding Problem

### Endocrine
O **Denies All** O Heat Intolerance O Cold Intolerance O Fatigue