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

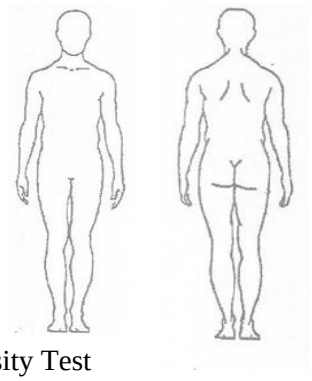
Have you had physical/occupational therapy? O Yes O No

If yes, where and date range? _____

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

If yes, where and by whom? _____

Mark where your symptoms



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	

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/Bizzing 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