RESURGENS PC
ORTHOPAEDICS
resurgens.com

Medical Record #: _____

Health History

Name:_____ Phone:_____ Date:_____

DOB:_____ Height _____ Weight _____ ❑ Male ❑ Female Updated:_____

Pregnant ❑ Yes ❑ No ❑ Unknown*

Primary Care Physician / Phone Number:

_____

PAST MEDICAL HISTORY:

Please check below if you have, or have had, any of these medical conditions:

❑ **NO PAST MEDICAL PROBLEMS**
❑ Acid reflux
❑ Adverse reaction to anesthesia
Type of reaction: _____
❑ Alzheimer's or significant memory loss
❑ Anemia
❑ **Angina or chest pain***
❑ **Asthma***
❑ **Atrial fibrillation***
❑ Bladder problems
❑ Bleeding ulcers
❑ **Blood clot***
❑ Legs ❑ Lungs
❑ **Cancer type:**_____*
Chemotherapy ❑ Yes ❑ No*
❑ **Cirrhosis***
❑ **Congestive heart failure***
❑ **Coronary artery disease***
❑ **Cystic Fibrosis***
❑ Dental disease
❑ Depression
❑ **Diabetes***
❑ **Down Syndrome***
❑ **Emphysema/COPD***
❑ **Epilepsy/Seizures***
❑ **Esophageal Varices***
❑ Fibromyalgia
❑ Gout
❑ **Heart Attack***
❑ **Hemophilia/Bleeding disorder***
❑ **Hepatitis***
❑ **High blood pressure/Hypertension***
❑ High cholesterol
❑ HIV or AIDS
❑ **Home Oxygen____Liters/minute***
❑ Infections:_____
MRSA? ❑ Yes ❑ No
❑ Irregular heartbeat
❑ **Kidney disease***
❑ **Dialysis***
❑ **Liver failure***
❑ **Malignant Hyperthermia***
❑ **Muscular Dystrophy***
❑ Osteoarthritis
❑ Osteoporosis
❑ Pneumonia
❑ Psychiatric disorder
❑ Rheumatoid arthritis
❑ **Sickle cell***
❑ **Sleep apnea***
❑ **CPAP machine**
❑ **Stroke (CVA)***
❑ Thyroid disease
❑ **TIA***
❑ Other not listed, explain:
_____

SURGICAL HISTORY:

Please check below if you have had any of these surgeries:

❑ **NO PREVIOUS SURGERY**

Abdominal
❑ Appendectomy
❑ Cholecystectomy / Gall Bladder
❑ Colon Surgery
❑ Gastric Bypass
❑ Hysterectomy
❑ Other _____

Vascular
❑ **Aneurysm***
❑ **Carotid Surgery***
❑ **Artery Bypass Stents Arm or Leg***

Cardiovascular Heart
❑ **Coronary Bypass (CABG)***
❑ **Heart Valve Replacement***
❑ **Pacemaker/Defibrillator***
❑ **Angioplasty/Stents***
❑ **Transplant***
❑ **Heart*** ❑ **Lung***

Other
❑ ENT
❑ Dental
❑ Breast Surgery
❑ Prostate Surgery
❑ Other _____

Orthopaedic
❑ Cervical Spine Surgery
❑ Lumbar Spine Surgery
❑ Upper Extremity
_____
❑ Lower Extremity
_____
❑ Other
_____
_____
_____
_____

Continued

NAME _____ DOB _____

Date of Visit: _____ Medical Record #: _____

LIST ALL KNOWN ALLERGIES TO MEDICATIONS: ❑ NO MEDICATION ALLERGIES

1. _____ Reaction type: _____
2. _____ Reaction type: _____
3. _____ Reaction type: _____

Are you allergic to latex? ❑ Yes ❑ No **If so what is the reaction?** _____

Tape allergy? ❑ Yes ❑ No **Are you allergic or sensitive to metals/nickel?** ❑ Yes ❑ No

CURRENT MEDICATIONS:

Include herbal and over-the-counter drugs. List all medications with dosage. Use additional sheet if needed.

❑ **NOT CURRENTLY TAKING MEDICATION**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

FAMILY HISTORY:

Please check below if any of your immediate relatives have had any of the following and list who:

❑ **NO FAMILY MEDICAL HISTORY TO REPORT**

❑ Adopted ❑ Yes ❑ No

❑ Adverse reaction to anesthesia Relation:_____

❑ Bleeding disorders Relation:_____

❑ Blood clots/Pulmonary embolism Relation:_____

❑ Cancer Relation:_____

❑ Depression Relation:_____

❑ Diabetes Relation:_____

❑ Heart disease Relation:_____

❑ Hypertension Relation:_____

❑ **Malignant Hyperthermia*** Relation:_____

❑ Osteoarthritis Relation:_____

❑ Osteoporosis Relation:_____

❑ Rheumatoid arthritis Relation:_____

❑ Stroke Relation:_____

❑ Other not listed, explain:

_____

_____

_____

SOCIAL HISTORY:

Marital status: ❑ Single ❑ Married ❑ Partner ❑ Divorced ❑ Widow/Widower

Hobbies _____ Have you served in the armed forces? Y ❑ N ❑

Smoking: ❑ Never smoked ❑ Former smoker ❑ Current smoker How many packs/day? _____

Do you dip or chew tobacco? Y ❑ N ❑ If Yes, how much per day? _____

Do you drink alcoholic beverages? Y ❑ N ❑ If Yes, how many drinks per week? _____

Do you use recreational drugs? Y ❑ N ❑ If Yes, what and how often? _____

REVIEW OF SYSTEMS:

Please check below if you have, or recently experienced, any of these medical conditions:

❑ **NO SYMPTOMS TO REPORT**

Abdominal pain: Y ❑ N ❑
Anxiety: Y ❑ N ❑
Arm/Leg pain: Y ❑ N ❑
Black, tarry stools: Y ❑ N ❑
Chest pain* Y ❑ N ❑
Dental problems: Y ❑ N ❑
Depression: Y ❑ N ❑
Easy bleeding/Bruising: Y ❑ N ❑
Fever/Chills/Night sweats: Y ❑ N ❑
Fatigue: Y ❑ N ❑
Gynecological problems: Y ❑ N ❑
Impotence: Y ❑ N ❑
Incontinence: Y ❑ N ❑
Irregular heart rate* Y ❑ N ❑
Leg swelling: Y ❑ N ❑
Palpitations* Y ❑ N ❑
Psychological problems: Y ❑ N ❑
Seizures* Y ❑ N ❑
Shortness of breath* Y ❑ N ❑
Skin wounds/Rashes: Y ❑ N ❑
Swollen glands: Y ❑ N ❑
Urinating at night: Y ❑ N ❑
Vascular problems: Y ❑ N ❑
Vision problems: Y ❑ N ❑
Weight gain: Y ❑ N ❑ Amount:_____
Weight loss: Y ❑ N ❑ Amount:_____

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Medical Record #: _____

History of Present Illness/Injury

Name_____ Date _____

DOB _____ Age _____

Left / Right handed (circle) Occupation _____

Primary care physician _____ **Who referred you?** _____

COMPLAINT/PROBLEM TODAY: _____

_____

Date of injury/Accident/Onset of problem _____

If injury/accident, describe what happened _____

_____

Is the injury/problem work-related? ❑ Yes ❑ No If Yes, please explain _____

_____

Occupation, at time of work injury _____

Work status ❑ Currently working full duty ❑ Light duty ❑ Not currently working

List all treatment history for this problem/injury _____

_____

_____

Severity of pain *(0= no pain, 10=worst pain)* At best _____ At worst _____ Today _____

Is pain localized or does it affect other body areas? ❑ Localized ❑ Other body areas

How does it affect other body areas? _____

_____

Other symptoms *(numbness, tingling, weakness, etc.)* _____

Have you seen one of our physicians in the past? If so, who? _____

For this recent injury/illness, have you had any recent X-rays, MRI, CT, or Bone Scan? (Please circle)

Continued

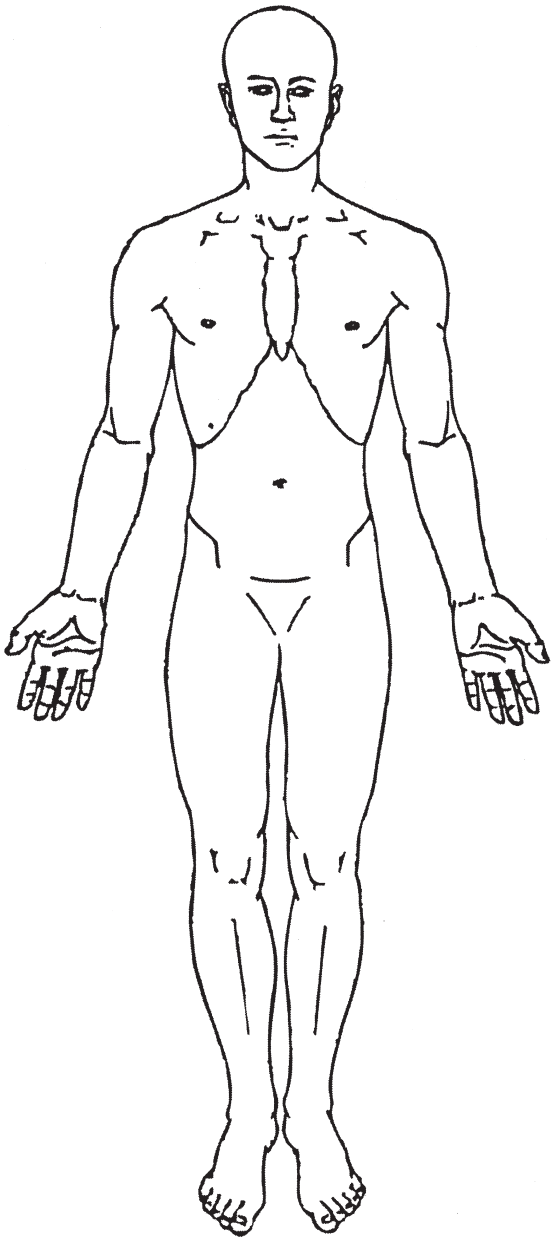
PAIN DRAWING

Date of Visit: _____ Medical Record #: _____

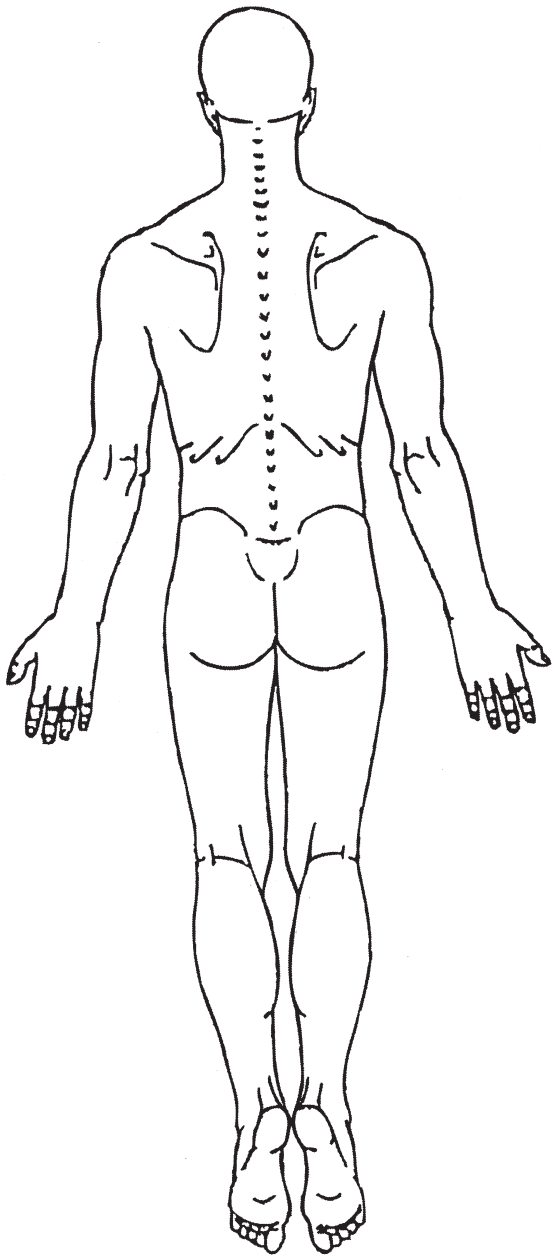
Mark these drawings according to where you hurt (i.e., if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

Key: **Stabbing ///** **Burning XXX** **Pins & Needles 000** **Numbness ===** **Aching +++**

Right



Left



Right

PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

Check the worst & best it's been and circle your current pain level.

KEY

0	**No pain.**
1	**Mild pain: you are aware of it, but it doesn't bother you**
2	**Moderate pain that you can tolerate without medication**
3	**Moderate pain that requires medication to tolerate**
4-5	**More severe pain: you begin to feel antisocial**
6	**Severe pain**
7-9	**Intensely severe pain**
10	**Most severe pain**

NAME_____ **DOB**_____

RESURGENS PC
ORTHOPAEDICS

Lower Extremity Diagnostic Questionnaire

Please check below:

1. Do you experience a dull or aching sensation in your knees when going up and down stairs/hills?	❑ Yes	❑ No
2. Do you experience pain in your heel(s) in the early morning or after prolonged periods of standing?	❑ Yes	❑ No
3. Do you experience any pain or burning sensation in the back of the heel or ankle area?	❑ Yes	❑ No
4. Do you experience pain in you big toe(s) or have bunions?	❑ Yes	❑ No
5. Have you developed any corns or calluses on your feet?	❑ Yes	❑ No
6. Do you experience shin splints?	❑ Yes	❑ No
7. Do you ever have “pins and needles” type tingling or loss of sensation in your toes?	❑ Yes	❑ No
8. Do you experience low back pain that travels down the back of your leg?	❑ Yes	❑ No

Consent to Treatment and Other Acknowledgments

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following:

PROCEDURES: During the course of my care and treatment, I understand that various types of examinations, tests, diagnostic or treatment procedures ("procedures") may be necessary. These procedures may be performed by physician(s), nurses, technicians, physician assistants, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.

NO GUARANTEE OF RESULTS: Resurgens physicians and healthcare professionals cannot guarantee any specific result(s) of any examination, treatment, procedure or medical care. I release Resurgens, its physicians and healthcare professionals from any liability for any accident or injury that is not directly caused by the negligence of Resurgens or its employees.

PROVIDING ACCURATE INFORMATION: I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

INDEPENDENT CONTRACTORS: Resurgens may utilize independent contractors for office, outpatient or inpatient treatment/procedures. These include, but are not limited to, surgical assistants, physical therapists, and consulting and referral physicians. Healthcare professionals that are independent contractors are not agents or employees of Resurgens and are responsible for their own actions. I understand that Resurgens shall not be liable for the acts or omissions of independent contractors. This Consent to Treatment also applies to any independent contractor utilized by my physician(s).

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD PARTY PAYMENTS: I hereby expressly authorize Resurgens and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to Resurgens and all professionals (including independent contractors) providing for such care, and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to Resurgens and the third party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.

PAYMENT FOR SERVICES: In return for services to be provided by Resurgens, I promise to pay for services rendered by Resurgens to me or for my benefit. If the services I receive from Resurgens are covered by a third party payor, Resurgens may elect to bill and accept payment from such third party. I will pay the portion of these bills which the third party payor determines are my responsibility. In the case of services which I agree to receive but which are not covered by the third party, I will pay the amount due upon receipt of services. I acknowledge that Resurgens will attempt to obtain or confirm benefits and coverage information from my insurance company or other third party payer, but that this is not a guarantee of coverage or payment, nor does it release me from any payment obligation for the services that I receive. If no third party is involved in paying for my services, I agree to pay in full for such services at the time the services are received.

AUTHORIZATION AND RELEASE FOR PHOTOGRAPHS: I authorize and release Resurgens and its employees and agents to take photographs, videos, x-rays, and/or other photographic, electronic or other images of me and to use them as may be medically appropriate. Such images may be used for educational or other purposes as necessary and appropriate. These images may be maintained as a permanent part of my medical record. I understand and acknowledge that Resurgens may use cameras for security and patient monitoring, and patient confidentiality will be maintained for all such images. However we do not allow videotaping, recording or photography in the office without the physician's permission.

VALUABLES: Resurgens assumes no responsibility for, and I hereby release Resurgens from liability for, loss or damage to any of my personal property while on the premises and/or receiving treatment.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits).

_____ Date: _____

Patient/Parent/Guardian/Authorized Representative

If not signed by the patient, please indicate relationship to the patient on the line below:

_____

A copy of this document may be utilized the same as the original.
Revision July 2014

RESURGENS PC
ORTHOPAEDICS

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that the Resurgens Privacy Notice Revision Date, August 5, 2013 has been made available to me. A paper copy of this Notice will be provided at my request. This Notice is also displayed in the waiting room and on the Resurgens' website www.resurgens.com. Initials: _____

MRN:

Authorization to Release Protected Health Information

I, _____, hereby authorized Resurgens Orthopaedics to release my protected health information to the following: (Please check and provide the NAME or specific entities to who your protected health information may be given.)

_____ Family members or friends: (please give names) _____

_____

_____ School or Employer: (list names of school/coach/employer) _____

_____

_____ Other: _____

Initials: _____

This authorization shall be in effect (please check one).

_____ no expiration date _____ expiration date of _____

_____ _____
Patient or Personal Representative's Name Printed

X _____ _____
Patient or Personal Representative's Signature Date

Office Use - Documentation of Good Faith Effort

The patient identified above was made aware of the availability of the Privacy Notice on this date. A good faith effort has been to obtain a written acknowledgement of this. However, acknowledgement has not been obtained because:

___ Patient refused to sign the Privacy Notice Acknowledgement

___ Patient was unable because: _____

___ There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical

___ Other reason, describe: _____

_____
Resurgens Employee Printed Name and Signature

RESURGENS PC
ORTHOPAEDICS

NARCOTIC CONTRACT AND PRESCRIPTION REFILL POLICY

1. I agree to allow 48 hours for prescription refills.
2. I understand that prescription refills requested after 4:00 pm will not be received until the next business day.
3. I understand that a follow-up visit may be required from my physician in order to obtain a refill.
4. I agree to take all medication exactly as instructed. I am NOT allowed to change the dosage amounts or alter the time schedule of taking the medication without first speaking to my physician.
5. I understand that narcotics and non-narcotic medications will NOT be phoned in after hours or on the weekends.
6. Patients may be terminated from the practice with 30 days' notice for noncompliance in the taking of their medications. In order to ensure compliance, Resurgens reserves the right to perform random drug screen monitoring on patients who require prescription narcotic medications over an extended period of time, as required by law. Refusal to cooperate with a drug screen likewise will constitute a basis for termination from the practice. I certify that I will voluntarily provide a fresh and unadulterated saliva or urine specimen for testing.
7. Resurgens will NOT refill prescriptions that have been lost or misplaced.
8. I must keep all appointments as recommended.
9. I will not give, trade, or sell medications.
10. The following are specific (but not exclusive) grounds for immediate termination from the practice:
    1) Obtaining narcotics from any other physician while under Resurgens' care.
    2) Altering or forging of a prescription. ***This is a felony and will be reported.***
11. I am aware that most of the manufacturers of drugs used to treat chronic pain recommend against the operation of heavy equipment, which includes driving a motor vehicle. I am aware that if I choose to drive a vehicle I could be charged with a DUI.
12. I will not combine any narcotic medications with the consumption of alcohol.
13. I understand that only one pharmacy may be used for filling my prescriptions.

    My pharmacy's name and location is: _____

    _____

(Please notify us if you change pharmacies.) Pharmacy's Phone Number: _____

I have read, understand and agree to the policies above. I understand that if I do not sign this document, my physician may refuse to prescribe narcotic medications to treat my pain. I acknowledge having been provided a document entitled Controlled Substance Agreement and Informed Consent Form, and that I have a right to a paper copy upon request or can obtain a copy on the Resurgens website at http://www.resurgens.com, and I have had the opportunity to ask questions and receive answers to my satisfaction.

Patient Name (*Please Print*): _____

Patient Signature: _____ **Date:** _____

Board Approved 5/14/14 -- Effective 5/14/14 FRMPAINMEDRX
Revised 5/14/14

RESURGENS PC
ORTHOPAEDICS

Controlled Substance Agreement and Informed Consent Form

In May of 2011 Governor Nathan Deal signed into law SB 36, the Patient Safety Act of 2011, making Georgia one of the last states in the nation to provide legislation for the implementation of a prescription drug monitoring program (PDMP) to combat the growing problem of prescription drug abuse. As a result of this legislation and in the interest of promoting patient safety, the Georgia Composite Medical Board issued updated pain management minimum standards of practice (Rule 360.3.06) which require physicians to monitor patients to avoid narcotic dependency and addiction. A violation of these rules could subject the physician to sanctions and, more importantly, put patients at risk. The goal is to educate patients about the risks of long term narcotic use and reduce prescription drug abuse.

During the course of your treatment, your doctor may recommend the use of controlled substances to treat your orthopaedic problem pre and post operatively. The purpose of this document is to make you aware of the risks, benefits and alternatives of taking controlled substance medications in the treatment of pain and that there are federal and state laws regulating the prescribing of controlled substances which require your physician to closely monitor patients who receive these medications to avoid injury as a result of misuse, abuse, tolerance, dependency or addiction. You will be asked to sign the **Resurgens Narcotic Contract and Prescription Refill Policy** which sets out the terms and conditions required to receive controlled substance medications and the consequences of non-compliance. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed and of our commitment to ensure that your pain is managed in a safe and effective manner.

I hereby consent to being prescribed controlled substance(s), or narcotic medication(s) as an element in the treatment of my pain. I further understand that these medication(s) are addictive and may, like other drugs used in the practice of medicine, produce adverse affects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

Benefits: When taken as directed by my physician, narcotic medications can be used safely and will decrease pain, improve function and quality of life.

Risks: The most common side effects and complications are constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention, insomnia, depression, impairment of reasoning and judgment, respiratory depression, impotence, tolerance to medication(s), physical and emotional dependence, addiction and death.

Alternatives: Continue with conservative treatment and non-narcotic pain medications.

I understand that my physician may obtain medical records from prior treating physicians and a medication profile from my pharmacy to monitor my compliance and I agree to make other medical providers aware of my use of controlled substances since use of other drugs may cause me harm.

I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

I must keep all regular follow up appointments as recommended by my physician and that failure to comply may cause discontinuation of narcotic prescription(s).

I acknowledge understanding of the information contained herein by signing the **Resurgens Narcotic Contract and Prescription Refill Policy** and understand that my physician will answer any additional questions I may have. With full knowledge of the potential benefits, possible risks and alternatives involved, I agree to the use of controlled substances if prescribed and agree to comply with the terms and conditions of the **Resurgens Narcotic Contract and Prescription Refill Policy**.

Created 4/11/2012
Revised 10/9/12

RESURGENS PC
ORTHOPAEDICS
REACH for MORE

Patient Name _____

MRN _____

How did you first hear about our office?

Please select one of the following:

- ☐ Internet
  - ☐ Google Search
  - ☐ Online Advertising
  - ☐ Facebook
  - ☐ Email
  - ☐ Website
  - ☐ Other: _____
- ☐ Billboard
- ☐ Gym
- ☐ Radio Station
- ☐ Newspaper/Magazine
- ☐ TV Commercial
- ☐ Friend or Family: _____
- ☐ Primary Care Physician: _____
- ☐ Other Physician: _____
- ☐ Self (You've known Resurgens for years!)
- ☐ ER
- ☐ Urgent Care
- ☐ Employer
- ☐ Insurance Company
- ☐ Yellow Pages
- ☐ Health Fair Event
- ☐ Attorney

Why do we need your e-mail address?

- To invite you to join our patient portal. The invitation will come from Follow My Health. Once you join, it will enable you to access your test results, receive summaries of your visit, communicate securely with your doctor and clinical team regarding your treatment, and pay your bill on-line.
- To send you health questionnaires to help your doctor better monitor your progress and ensure that your treatment goals are met.
- To send you a survey asking for your opinions to help us improve our services.

☐ My E-mail address _____

☐ I do not have e-mail

☐ I do not wish to share my e-mail address

Signature _____ Date _____