GEORGIA
Hand, Shoulder & Elbow

PATIENT INFORMATION
GEORGIA HAND, SHOULDER & ELBOW

Please complete this form. It is a **confidential** part of your medical record. If you have any questions about this form, please ask our front desk personnel. You must fill out **completely** prior to being seen.

DEMOGRAPHICS

Patient Name: _____ Date: _____
(Last Name) (First Name) (M.I)

Sex: ◯ M ◯ F Date of Birth: _____ Age: _____ Social Security Number: _____
Race: _____

Home Address: _____ Home Phone#: _____
_____ Work Phone#: _____
City, State, Zip: _____, ___ _____ Cell Phone#: _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widow Spouse Name: _____

Work Related: ◯ Yes ◯ No Specific Job: _____

Patient's Occupation: _____ Name of Employer: _____

Years of Service: _____

Current Work Status: ◯ Regular Duty ◯ Light Duty ◯ Off Work

Hobbies/Musical Instruments: _____

INSURANCE INFORMATION

Do you have insurance? ◯ Yes ◯ No

Primary Insurance Coverage: _____ Policy Holder: _____

Policy Holder Social Security#: _____ Relationship to Policy Holder: _____

ID or Plan#: _____ Policy Holder DOB: _____

Group #: _____

Secondary Insurance Coverage: _____ Policy Holder: _____

Policy Holder Social Security#: _____ Relationship to Policy Holder: _____

ID or Plan#: _____ Policy Holder DOB: _____

Group #: _____

Insured's Employer: _____ Employer Phone#: _____

If patient is a MINOR, Responsible Party Name: _____ Relationship to patient: _____

Address: _____

Responsible Party Home Phone#: _____ Work Phone #: _____

Print Form

Patient Name: _____

I was referred by: _____

Pharmacy Name: _____ Phone Number: _____

Chief reason for today's evaluation: _____

I am: (__ Right __ Left) Handed Date of Injury or onset of condition: _____

Describe accident or injury:

Describe all previous treatments for your condition:

Severity of Symptoms from 1 to 10: ___

Body parts affected: Right: __ Hand __ Wrist __ Forearm __ Elbow __ Shoulder Neck: __

Left: __ Hand __ Wrist __ Forearm __ Elbow __ Shoulder

GENERAL INFORMATION

Please List Your Medication Allergies **Reaction** **__ No Known Drug Allergies**

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Please List Your Current Medications and Dosage (Prescriptions, Over-the-Counter, and Herbal) **__ None**

1. _____
2. _____
3. _____
4. _____

Please List Previous Surgeries: **Date of Surgery**

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Print Form

Patient Name: _____

Are you pregnant:	○YES ⊙NO
Do you take prescription blood thinners (Coumadin, Plavix, or Lovenox)?	○YES ⊙NO
Do you take aspirin or anti-inflammatory medicines every day?	○YES ⊙NO
Do you have heart valve problems?	○YES ⊙NO
Have you had a joint or heart valve replacement?	○YES ⊙NO
Are you allergic to latex?	○YES ⊙NO
Are you allergic to intravenous contrast (dye)?	○YES ⊙NO

MEDICAL HISTORY: (REVIEW OF SYSTEMS)

EYES

Wear Contacts	○YES ⊙NO
Wear Glasses	○YES ⊙NO
Glaucoma	○YES ⊙NO
Cataracts	○YES ⊙NO

EARS/NOSE/THROAT

Hearing loss or ringing	○YES ⊙NO
Sinus Congestion	○YES ⊙NO

ENDOCRINE

Diabetes	○YES ⊙NO
Hypothyroidism	○YES ⊙NO
Hyperthyroidism	○YES ⊙NO
Hypercholestermia	○YES ⊙NO

CARDIOVASCULAR

Hypertension	○YES ⊙NO
Chest Pain	○YES ⊙NO
Heart Attack	○YES ⊙NO
Congestive Heart Failure	○YES ⊙NO
Abnormal EKG in past	○YES ⊙NO
Irregular Heart Beat	○YES ⊙NO
Mitral Valve Prolapse	○YES ⊙NO
Coronary Artery Disorder	○YES ⊙NO

RESPIRATORY

Asthma	○YES ⊙NO
Emphysema	○YES ⊙NO
Bronchitis	○YES ⊙NO
Chronic Cough	○YES ⊙NO
Sleep Apnea	○YES ⊙NO
I use CPAP	○YES ⊙NO
COPD	○YES ⊙NO

GASTROINSTESTINAL

Bleeding Ulcers	○YES ⊙NO
IBS	○YES ⊙NO
Acid Reflux	○YES ⊙NO
Gallstones	○YES ⊙NO

GENITOURINARY

Kidney Stones	○YES ⊙NO
Kidney Failure	○YES ⊙NO

MUSCULOSKELETAL

Muscle Weakness	○YES ⊙NO
Osteoporosis	○YES ⊙NO
Osteopenia	○YES ⊙NO
Osteoarthritis	○YES ⊙NO

RHEUMATOLOGIC DISEASE

Rheumatoid Arthritis	○YES ⊙NO
Systemic Lupus Erythematosus	○YES ⊙NO
Psoriatic Arthritis	○YES ⊙NO
Scleroderma	○YES ⊙NO
Sjörgen's Disease	○YES ⊙NO
Other:	

NEUROLOGICAL

Stroke	○YES ⊙NO
Seizure Disorder	○YES ⊙NO
Paralysis	○YES ⊙NO
Other:	○YES ⊙NO

DERMATOLOGICAL (Skin)

Psoriasis	○YES ⊙NO
Eczema	○YES ⊙NO
Acne	○YES ⊙NO

PSYCHIATRIC

Depression	○YES ⊙NO
Anxiety Disorder	○YES ⊙NO
Other:	

HEMATOLOGICAL/LYMPHATIC

Leukemia	○YES ⊙NO
Lymphoma	○YES ⊙NO
HIV Positive	○YES ⊙NO
Von Willebrand's Disease	○YES ⊙NO
Sickle Cell Disease	○YES ⊙NO
Sickle Trait	○YES ⊙NO
Hepatitis A, B, or C	○YES ⊙NO
Liver Disease	○YES ⊙NO

CANCER? If Yes, Please List: _____

USE OF ALCOHOL: ○ **Never** ○ **Social** ○ **Daily**

USE OF TOBACCO: ○ **Never** ○ **Former**
○ **Current, Packs/Day:** ____

Print Form

FINANCIAL POLICY

At Georgia Hand, Shoulder & Elbow, we are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines:

1. Payment is due at the time of service.
2. We will file your insurance for you if we are a participating provider of your plan. We will make every attempt to verify your coverage at the time of service. Since insurance plans cannot guarantee eligibility or benefits, we cannot do so either. You will be responsible for any and all services in excess of your insurance limits, as well as all non covered services.
3. All co-payments are due at the time of service.
4. If we are not participating providers of your plan, payment in full is expected today. Please understand that if we do not participate in your plan, any associated surgery, testing or therapy may not be covered as well.
5. Claims for patients with insurance plans that have out-of-network benefits will be filed as a courtesy and any reimbursement will come to you directly from the insurance company.
6. Patients covered under Workman's Compensation may be responsible for payment if the claim is controverted.
7. **All copayments, unmet deductibles and any amounts deemed by your insurance policy that are the responsibility of the patient are due and payable prior to surgery.**

I have read and understand the Financial Policy.

_____ _____

Signature Date

CONSENT TO CALL

I consent to receive calls from Georgia Hand, Shoulder & Elbow for my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

_____ _____

Signature Date

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1966 (HIPAA)

I have been given the opportunity to review/obtain a copy of Georgia Hand, Shoulder & Elbow's Notice of Privacy Practices.

_____ _____

Signature Date

Print Form