



PATIENT INFORMATION FORM

Southern Bone & Joint Specialists, P.A. ("SBJ") and Southern Surgery Center, LLC ("SSC") are separate legal entities and neither is responsible for the debts or liabilities of the other. This Patient Information Form and Agreement for both entities is provided for convenience and to reduce the amount of paperwork particularly in connection with patients who may be treated by physicians of SBJ and have surgery or other procedures at SSC. SSC is owned by the physicians at SBJ.

Date: Patient No.: Patient SSN:

Patient's Name: First Middle Initial Maiden Name Last

Patient's Address: Apt. # City State Zip Code

Home Phone: Work Phone: Cell Phone:

Email: Sex: M F Birth Date: Age: Marital Status: Single Married Divorced Widowed Separated

Spouse's / Guardian's Name (if applicable): DOB: SSN:

Physician Seeing Today: Date of Injury / Accident: Were you injured on the job? Yes No

If a sports related injury, list school & sport: Have you been a patient of this Clinic before? Yes No If yes, when?

Who referred you to this Clinic? If Physician, list phone and city:

Do you live in a skilled nursing facility? Yes No If yes, name of facility: Phone:

PATIENT'S INFORMATION

SPOUSE'S / PARENT'S / GUARDIAN'S INFORMATION (if applicable)

Employer:

Employer:

Address:

Address:

City, State, Zip:

City, State, Zip:

Occupation: Phone:

Occupation: Phone:

Nearest relative not living with you: Relationship: Phone:

Relative's Address: City, State, Zip:

INSURANCE COVERAGE INFORMATION

Primary: ID#: Group #: Subscriber's Name:

Subscriber's Date of Birth: Sex: M F

Secondary: ID#: Group #: Subscriber's Name:

Subscriber's Date of Birth: Sex: M F

Other: ID#: Group #: Subscriber's Name:

Subscriber's Date of Birth: Sex: M F

If you have insurance, we will be glad to help you file for any benefits to which you are entitled. However, it remains the responsibility of the individual patient to settle his / her account promptly. To help us file your insurance claim correctly, please fill in the above insurance information. We will also need a copy of your insurance card.

BILLING INFORMATION

Responsible Party: Relationship to Patient: SSN:

Address: Phone:

Employer's Name: Give reason for billing, if billing someone other than patient or immediate family:



PATIENT INFORMATION FORM

PAYMENT

CLINIC POLICY: I am responsible for payment of all charges for services and products rendered or provided to me by Southern Bone & Joint Specialists, P.A. (SBJ) and Southern Surgery Center, LLC (SSC).

MEDICARE AND/OR MEDICAID: I hereby request that payment of authorized Medicare/Medicaid benefits to or on my behalf for services furnished in or by SBJ and/or SSC, shall be made to SBJ and/or SSC, and I specifically assign such benefits to SBJ and/or SSC.

INSURANCE: I hereby assign to SBJ and/or SSC all rights, benefits and interest under any insurance policy, health plan, Workers' Compensation or other third party payor liable to me, in consideration for services rendered by SBJ and/or SSC.

Signature: _____ Date: _____
(Signature is required for all patients or responsible parties)

(If signing on behalf of a minor as parent or legal guardian, the responsible party agrees and acknowledges the foregoing on behalf of the minor and represents that he / she has full power and authority to do so.)

CONSENT FOR TREATMENT

The undersigned authorizes the Physician and / or Physician Assistant and / or Nurse Practitioner assigned to furnish medical and surgical treatment by those means he / she considers necessary and proper in treatment of the patient identified below while a patient of SBJ and SSC.

Signature: _____ Date: _____
(Signature is required for all patients or responsible parties)

(If signing on behalf of a minor as parent or legal guardian, the responsible party agrees and acknowledges the foregoing on behalf of the minor and represents that he / she has full power and authority to do so.)

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION / POLICIES AND PROCEDURES / NARCOTIC/CONTROLLED SUBSTANCES CONSENT FORM

I have received and had an opportunity to ask questions concerning SBJ's and SSC's Notice of Privacy Practices for Protected Health Information.

Signature: _____ Date: _____

I have received and had an opportunity to ask questions concerning SBJ's and SSC's Policies and Procedures.

Signature: _____ Date: _____

I have received and had an opportunity to ask questions concerning SBJ's and SSC's Narcotic / Controlled Substances Informed Consent for Treatment form.

Signature: _____ Date: _____



MEDICAL HISTORY

MEDICAL HISTORY

Please check any of the following medical problems or symptoms you currently have or have had:

- NO SIGNIFICANT HISTORY, DIABETES, OTHER, CANCER, HIGH BLOOD PRESSURE

Is there a possibility you are pregnant? Have you gone through menopause? Are you going through menopause?

PAST SURGICAL INTERVENTION

List any other surgeries and year of surgery:

ORTHOPEDIC

Please check any of the following orthopedic surgeries you have had:

- ANKLE, ELBOW, HIP, KNEE, NECK, SHOULDER, SPINE, WRIST

List any previous fractures:

List any other ortho surgeries and year of surgery:

MEDICATIONS AND ALLERGIES

Are you currently taking any medications? If yes, please list:

Do you have medication allergies? If yes, please list what they are and the type of reaction it causes:

Do you have any other allergies? If yes, please list what they are and the type of reaction it causes:

PAST FAMILY HISTORY

Has anyone in your immediate family (father, mother, siblings, grandfather, grandmother, spouse) ever been diagnosed with any of the following medical conditions? If so, who?

- NO SIGNIFICANT FAMILY HISTORY, DIABETES, OTHER, CANCER, HYPERTENSION

SOCIAL HISTORY / LIFESTYLE

Level of education completed, Number of children, Are you retired?, Are you disabled?, Activity Level, Exercise Frequency, Type of exercise, Hobbies / activities, Special diet requirements

HABITUAL USE

Do you use any tobacco products? Do you drink alcohol? Do you consume caffeine? Do you use illicit drugs?



INTAKE FORMS

Patient's Name: _____
First Middle Initial Last

CURRENT HEALTH PROBLEM(S) AND RECENT TESTS

Your current health problem is primarily confined to the following area(s): (Please check all that apply.)

- Checkboxes for Ankle, Back, Hand, Leg, Wrist, Arm, Elbow, Hip, Neck, Other, Back (Lower), Foot, Knee, Shoulder.

Describe your problem in detail: _____

How and when did it begin? _____

Does the pain keep you awake at night? Yes No If yes, how often? _____

Have you ever seen an orthopaedic surgeon about this problem? Yes No If yes, when? _____

Date you were first treated: _____ Date you returned to work: _____

Have you been treated for your current problem in the past? Yes No If yes, when? By whom? _____

Have you had surgery on this area in the past? Yes No If yes, when? By whom? _____

Have you had any of the following tests performed recently for this condition?

- Checkboxes for CAT scan, CT/Myelogram, Discogram, MRI scan, Nerve test(s), X-Rays, Other test(s) with fields for When, Where, Results.

REVIEW OF SYMPTOMS: (Please check any symptom(s) you have.)

- HEENT: Headache, Blurred vision, Change in vision, Spots in eyes, Ringing in ears, Vertigo, Poor balance, Frequent nose bleeds, Change in voice, Difficulty or pain swallowing.
Pulmonary: Frequent coughing, Coughing up blood, Shortness of breath.
Cardiac: Racing heart, Irregular heartbeat, Swelling of legs and feet, Pain in chest.
GI: Vomiting blood, Black stools, Bloody stools, Frequent diarrhea, Constipation, Loss of control of bowel.
GU: Difficulty urinating, Frequent, uncontrolled wetting of pants, Burning with urination, Drainage from penis or discharge from vagina, Lumps in testicles.
Renal: Blood in urine, Recent increase or decrease in amount or frequency of urination.
Psych: Unable to sleep, Sleep all the time, Hear voices, Panic attacks.
Neurological: Sudden difficulty with, or inability to speak, Sudden numbness or paralysis on half or part of body, Sudden blindness or blind spots.



INTAKE FORMS

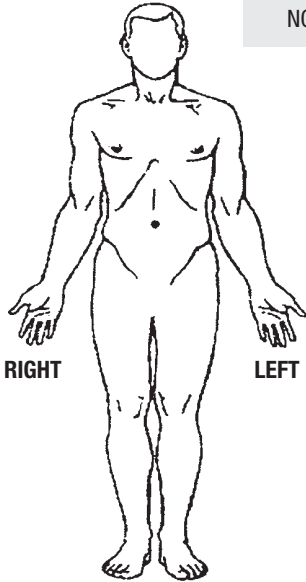
LEVEL / AREA(S) OF PAIN

Circle the number that best represents the level of pain you are currently experiencing:

0 1 2 3 4 5 6 7 8 9 10

NONE MILD MODERATE SEVERE VERY SEVERE WORST POSSIBLE

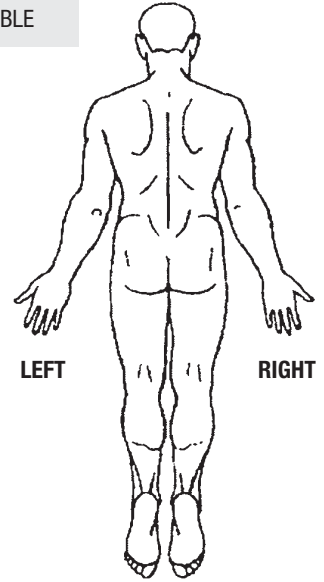
FRONT



RIGHT

LEFT

BACK



LEFT

RIGHT

Use the body diagrams to show where you feel the following sensations:

ACHE NUMBNESS BURNING

AA 00 //
AA 00 //

STABBING PINS & NEEDLES

XX ++
XX ++

GENERAL

Using the level of pain chart above, indicate the # that best describes the pain in that certain area:

- L / R Ankle: Level of Pain: _____
- L / R Back: Level of Pain: _____
- L / R Elbow: Level of Pain: _____
- L / R Foot: Level of Pain: _____
- L / R Hand: Level of Pain: _____
- L / R Hip: Level of Pain: _____
- L / R Knee: Level of Pain: _____
- L / R Neck: Level of Pain: _____
- L / R Shoulder: Level of Pain: _____
- L / R Wrist: Level of Pain: _____

Are you currently working? Yes No If no, what was the date you last worked? _____

What type of work do you perform? _____

Which hand do you write with? Right Left

Which hand is your dominant hand? Right Left Both

Have you had any previous upper extremity injuries? Yes No If yes, when? _____

Have you had any injections for your condition? Yes No If yes, when? _____

Have you had any physical therapy for your condition? Yes No If yes, when? _____

Have you performed any exercises for your condition? Yes No If yes, what kind? _____

Have you been to a Chiropractor for your condition? Yes No If yes, when? _____

Have you used a walker, cane or any other type of support? Yes No If yes, please list: _____



Patient's Name: _____
First Middle Initial Last

BACK (OSWESTRY QUESTIONNAIRE)

I have problems with my back and that is why I am seeing the doctor today.

- YES. Please answer the questions below. NO. Please skip this section.

BACK QUESTIONNAIRE:

This questionnaire is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life. Please answer every section. Check ONE BOX ONLY in each section that most closely describes your problem right now.

SECTION 1 – PAIN INTENSITY

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

SECTION 2 – PERSONAL CARE (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it is very painful.
- It is painful to look after myself and I am slow and careful.
- I need some help, but manage most of my personal care.
- I need help everyday in most aspects of self care.
- I do not get dressed, wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

SECTION 4 – WALKING

- Pain does not prevent me from walking any distance.
- Pain prevents me walking more than 1 mile.
- Pain prevents me walking more than 1/2 mile.
- Pain prevents me walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – SITTING

- I can sit still in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me sitting more than 1 hour.
- Pain prevents me sitting more than 1/2 hour.
- Pain prevents me sitting more than 10 minutes.
- Pain prevents me from sitting at all.

SECTION 6 – STANDING

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing more than 1/2 hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

SECTION 7 – SLEEPING

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain I have less than 6 hours sleep.
- Because of pain I have less than 4 hours sleep.
- Because of pain I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

SECTION 8 – SEX LIFE

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

SECTION 9 – SOCIAL LIFE

- My social life is normal and gives no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

SECTION 10 – TRAVELING

- I can travel anywhere without extra pain.
- I can travel anywhere but it gives me extra pain.
- Pain is bad but I can manage journeys over two hours.
- Pain restricts me to journeys of less than one hour.
- Pain restricts me to short necessary journeys under thirty minutes.
- Pain prevents me from traveling except to receive treatment.



INTAKE FORMS

NECK

I have problems with my neck and that is why I am seeing the doctor today.

- YES. Please answer the questions below. NO. Please skip this section.

NECK PAIN DISABILITY INDEX QUESTIONNAIRE:

This questionnaire is designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section. Check ONE BOX ONLY in each section that most closely describes your problem right now.

SECTION 1 – PAIN INTENSITY

- I have no pain at the moment. The pain is very mild at the moment. The pain is moderate at the moment. The pain is fairly severe at the moment. The pain is very severe at the moment. The pain is the worst imaginable at the moment.

SECTION 2 – PERSONAL CARE (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain. I can look after myself normally but it causes extra pain. It is painful to look after myself and I am slow and careful. I need some help, but manage most of my personal care. I need help everyday in most aspects of self care. I do not get dressed, wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- I can lift heavy weights without extra pain. I can lift heavy weights, but it gives extra pain. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned. I can lift only very light weights. I cannot lift or carry anything at all.

SECTION 4 – READING

- I can read as much as I want to with no pain in my neck. I can read as much as I want to with slight pain in my neck. I can read as much as I want with moderate pain in my neck. I cannot read as much as I want because of moderate pain in my neck. I cannot read as much as I want because of severe pain in my neck. I cannot read at all.

SECTION 5 – HEADACHES

- I have no headache at all. I have slight headaches which come infrequently. I have moderate headaches which come infrequently. I have moderate headaches which come frequently. I have severe headaches which come frequently. I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- I can concentrate fully when I want to with no difficulty. I can concentrate fully when I want to with slight difficulty. I have a fair degree of difficulty in concentrating when I want to. I have a lot of difficulty in concentrating when I want to. I have a great deal of difficulty in concentrating when I want to. I cannot concentrate at all.

SECTION 7 – WORK

- I can do as much work as I want to. I can only do my usual work, but no more. I can do most of my usual work, but no more. I cannot do my usual work. I can hardly do any work at all. I cannot do any work at all.

SECTION 8 – DRIVING

- I can drive my car without any neck pain. I can drive my car as long as I want with slight pain in my neck. I can drive my car as long as I want with moderate pain in my neck. I cannot drive my car as long as I want because of moderate pain in my neck. I can hardly drive at all because of severe pain in my neck. I cannot drive my car at all.

SECTION 9 – SLEEPING

- I have no trouble sleeping. My sleep is slightly disturbed (less than 1 hour sleepless). My sleep is mildly disturbed (1-2 hours sleepless). My sleep is moderately disturbed (2-3 hours sleepless). My sleep is greatly disturbed (3-5 hours sleepless). My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10 – RECREATION

- I am able to engage in all of my recreational activities with no neck pain at all. I am able to engage in all of my recreational activities with some pain in my neck. I am able to engage in most, but not all, of my usual recreational activities because of pain in my neck. I am able to engage in a few of my usual recreational activities because of pain in my neck. I can hardly do any recreational activities because of pain in my neck. I cannot do any recreational activities at all.



INTAKE FORMS

Patient's Name: _____
First Middle Initial Last

SPINE

I have problems with my spine and that is why I am seeing the doctor today.
YES. Please answer the questions below. NO. Please skip this section.

REVIEW OF SYMPTOMS: (Please check any symptom(s) you have.)

PAIN CHARACTER?

- Aching
Burning
Dull
Electrical
Numbness
Pins and Needles
Other

WHAT MAKES IT BETTER?

- Bending Back
Bending Forward
Coughing / Sneezing
Lying Down
Sitting
Standing
Walking
Nothing

WHAT MAKES IT WORSE?

- Bending Back
Bending Forward
Coughing / Sneezing
Lying Down
Sitting
Standing
Walking
Nothing

TREATMENTS SO FAR?

- Accupuncture
Anti-inflammatories
Chiropractic
Epidural Injections
Exercise / Yoga
Narcotics
Physical Therapy
Surgery

PHYSICIAN USE ONLY - LEAVE THE BELOW BLANK:

EXAM
Height: _____ Weight: _____ Pulse: _____

RANGE OF MOTION
Normal Decreased

GAIT
Normal
Antalgic
Trendelenberg
Heel / Toes Walk
PALPATION
No Pain
Parspinal Muscle Pain
Spasm
Spinous Process Pain

Table with 5 columns: SLR, L'HERMITTE'S, SPURLINGS'S, CLONUS, and rows for RIGHT and LEFT.

RADIOLOGY FINDINGS:
X-Rays:
CT/Myelogram:
MRI:
OTHER:

Motor function table for upper extremities: P-L1,2,3 Delt-C5; Quads-L3,4 Biceps-C5,6; Tib Ant-L4 WE-C6; EHL-L5 Tricep-C7; Gastroc-S1 FF-C8; Peroneal-S1 Intrins-T1.

Motor function table for lower extremities: Patella-L3,4 Biceps-C5; Achilles-S1 Biceps-C5,6; BrachRad-C6; Tricep-C7; Babinski Hoffman.

SENSATION
Normal Decreased

PLAN:

