South Carolina Sports Medicine & Orthopaedic Center

Patient Information Form

First Name: _____ MI: _____ Last name: _____ Goes by: _____

Age: _____ Date of Birth: ____/____/_____ SS#: _____-____-_____ Sex: M or F Marital Status: _____

Ethnicity: American Indian/Alaska Native Asian Black/African American Hispanic/Latino
Hawaiian/Pacific Islander White Other

Address: _____ Apt#: _____ City: _____ State: ____ Zip: _____

Home Phone: ( )_____-_____ Work: ( )_____-_____ Cell: ( )_____-_____ **Consent to text?** Y or N

Contact Preference: Home Phone Cell Phone Work Phone Email

Email address: _____ Employer/Occupation: _____

Insurance Policy Holders Name & DOB: _____

Family/Primary Care Doctor: _____Referring Doctor: _____

Pharmacy: _____ Address: _____Phone: ( )_____-_____

*******Who can we contact in case of emergency? Please list at least one person and their phone number: *******

Name: _____ Relationship: _____ Phone #: ( )_____-_____

**********IF THE PATIENT IS A CHILD OR A FULL TIME STUDENT, PLEASE COMPLETE THIS SECTION**********

Name of **RESPONSIBLE** party for this patient's bill: _____
(Note: Must be self, parent, or legal guardian)
Mailing Address: _____ Apt#: ____ City: _____ State: ____ Zip: _____

Name of School: _____ Address: _____

Mother's Name: _____ Date of Birth: _____ SS#: _____-_____-_____

Father's Name: _____ Date of Birth: _____ SS#: _____-_____-_____

Accident Questionnaire:

NO Accident _____ Auto Accident _____ Workers Compensation _____ School Injury _____ Other Accident _____

Date of injury: _____ Where did the injury occur? _____

How did the injury or accident occur? _____

Home Health/Skilled Nursing Facility Questionnaire

Are you currently receiving Home Health? ___Yes ___No

If yes, which agency is providing Home Health? _____

Are you currently residing in a skilled nursing facility? ___Yes ___No

If yes, what is the name of your skilled nursing facility? _____

PLEASE READ AND SIGN SECTIONS I, II AND

SECTION III OR IV PER INSURANCE TYPE

I. Financial Policy & Payment Responsibility: Payment for medical services is the responsibility of the patient or, in the case of a minor, the signed responsible party. Our office will file for insurance benefits for plans in which we **do participate**. Payment for deductible, co-insurance, and co-payment amounts will be collected from the patient at the time of service. If your insurance plan does not pay your medical services within 30 days, all charges may be due and payable in full from the patient. Your help in seeing that your insurance pays for your medical services within the specified time period is appreciated. I hereby acknowledge and accept full and final responsibility for payment of charges for medical services rendered. I understand that if payments for services rendered by this facility are not met, my account could be referred to an outside collection agency for further collection activity.

If my financial responsibility is not met when payment is due, SC Sports Medicine reserves the right to charge interest at the rate of 8% on any past due balance. If the patient no shows, or cancels their appointment repeatedly, their treating physician reserves the right to charge a $100 no show or frequent cancellation fee to the patient's bill.

For insurance plans in which we **do not participate:** full payment of charges will be collected from the patient at the time of service, unless special arrangements have been approved in advance.

We reserve the right to obtain a credit report and/or report to credit bureaus the status of your account due to delinquent account balances. A fee of $25.00 will be charged to your account for Returned Checks.

Patient or Responsible Party Signature: _____Date:_____

II. Consent for Treatment & Medical Release Authorization: I hereby consent to treatment for myself, my child, or named minor, for whom I am legally responsible. I authorize South Carolina Sports Medicine & Orthopaedic Center to release any medical information to any referring physician, other health care providers, hospitals and medical facilities, and to my insurance carriers and for the purpose of treatment, payment and health care operation. The release of medical information for insurance claims, the release of past medical payment history, if requested, is authorized. I understand that this information may include reference to psychiatric care, sexual assault, alcohol and/or drug abuse, and results of tests for all infectious diseases including AIDS/HIV. I furthermore, authorize South Carolina Sports Medicine and Orthopaedic Center's physicians and staff to discuss my Protected Health Information (PHI) in the presence of the family and visitors that accompany me during my visits.

Patient or Responsible Party Signature: _____Date:_____

III. Assignment of Insurance Benefits: I hereby assign and authorize payment to South Carolina Sports Medicine and Orthopaedic Center of all medical and surgical benefits to which I am entitled, including health insurance benefits, major medical benefits, and third party liability coverage including personal injury protection (PIP) benefits and other medical payment coverage for which I am entitled. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I hereby authorize South Carolina Sports Medicine and Orthopaedic Center to release all information necessary to secure payment of insurance benefits**. I understand that I am financially responsible for all charges whether or not paid by said insurance(s).**

Patient or Responsible Party Signature: _____Date:_____

IV. Medicare Insurance (SIGNATURE ON FILE): I request payment of authorized Medicare benefits be made payable to South Caroline Sports Medicine & Orthopaedic Center for any services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 forms or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and **non-covered** services. I authorize Health Care Financing Administration to release information to process claims for Medigap or secondary insurance.

Patient or Responsible Party Signature: _____Date:_____

☐ ***Please Initial box to acknowledge receipt/understanding of HIPAA information.***

*** If you would like to specify a person(s) rights to the privacy of your account please see the front desk receptionist for an additional form ***

South Carolina Sports Medicine & Orthopaedic Center

Patient Health History

Patient Name: _____ **Goes by:** _____ **Date:** ___ /____/___

Age_____ **Height**_____ ft _____ in **Weight**_____lbs **Referring Dr**._____

Reason for today's visit – What specific body part is causing the problem (Please Specify Left or Right)

_____

Accident Date/Onset of Problem_____ **How did the injury occur?** _____

Have x-rays been taken for this problem? YES / NO **When**: _____ **Where**: _____

Do you have your x-rays with you? YES / NO **Did you go to ER:** Yes or No **If Yes Where**:_____

Allergies: (Example: Penicillin - Hives)

Name of Drug / Food/ Material	Reaction	Name of Drug/Food/Material	Reaction
1._____		4._____	
2._____		5._____	
3._____		6._____	

Current Medications:

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

Did you have any surgical or anesthetic complications? _____

Do you have a pacemaker? Yes / No **Do you have any recent tattoos?** Yes / No

Do you have a stent or any implants /metal fragments in your body? Yes / No _____

Date of last: tetanus shot_____ **Flu shot**_____ **Pneumonia shot** _____ **Covid Vaccines**_____

Are you: Pregnant: Y or N **Breast Feeding** Y or N **Date of Last Period** _____

Medical History: Do you or any of your immediate family members have any of the following?

	YOURSELF	FAMILY	WHO		YOURSELF	FAMILY	WHO
International Travel	Y or N	Y or N	_____	Heart Attack (MI)	Y or N	Y or N	_____
AIDS/HIV	Y or N	Y or N	_____	Heart Disease	Y or N	Y or N	_____
Alcoholism	Y or N	Y or N	_____	Heart Murmur	Y or N	Y or N	_____
Anemia	Y or N	Y or N	_____	Hepatitis	Y or N	Y or N	_____
Anesthesia Probs	Y or N	Y or N	_____	High Blood Pressure	Y or N	Y or N	_____
Anxiety	Y or N	Y or N	_____	Kidney Disease	Y or N	Y or N	_____
Arthritis	Y or N	Y or N	_____	Liver Disease	Y or N	Y or N	_____
Asthma	Y or N	Y or N	_____	Lung Disease	Y or N	Y or N	_____
Bleeding Tend.	Y or N	Y or N	_____	Mood Disorder	Y or N	Y or N	_____
Blood Clot (lung/leg)	Y or N	Y or N	_____	Muscular Disease	Y or N	Y or N	_____
Blood Transfusion	Y or N	Y or N	_____	Prostate Disease	Y or N	Y or N	_____
Bone Disease	Y or N	Y or N	_____	Seizures	Y or N	Y or N	_____
Cancer	Y or N	Y or N	_____	Sickle Cell Disease	Y or N	Y or N	_____
Cholesterol Probs.	Y or N	Y or N	_____	Sleep Apnea	Y or N	Y or N	_____
Circulation Probs.	Y or N	Y or N	_____	Stomach Ulcers	Y or N	Y or N	_____
Depression	Y or N	Y or N	_____	Stroke	Y or N	Y or N	_____
Diabetes	Y or N	Y or N	_____	Thyroid Disease	Y or N	Y or N	_____
Fever	Y or N	Y or N	_____	Tuberculosis	Y or N	Y or N	_____
Fibromyalgia	Y or N	Y or N	_____	Varicose Veins	Y or N	Y or N	_____
GERD	Y or N	Y or N	_____	Urinary Tract Infect.	Y or N	Y or N	_____
Gout	Y or N	Y or N	_____	Other:	_____		

Family History: List ages of relatives below. If not living, list cause and age of death.

Mother's age_____ Brother(s) / Sister(s) age _____

Father's age_____ Children_____

Social History: Please answer all questions completely.

Occupation: _____ Employer_____

Marital Status: _____ School: _____ Grade: _____

Tobacco Use: Y or N or Former Smoker Type _____ Packs per Day _____ How long _____

Alcohol: Y or N Type_____ Amount per week _____

Drug Use: Y or N Type_____ Amount per week _____

Dominant Hand: Right or Left or Both **Are you under a pain contract?** Y/N Where: _____

Do you participate in Sports or other activities? Y or N / If yes please list: _____

Surgical History: Please list in order by year. Ex: Tonsillectomy – May 6, 1964

Name of Procedure	Year	Name of Procedure	Year
1._____		6._____	
2._____		7._____	
3._____		8._____	
4._____		9._____	
5._____		10._____	

Did you have any surgical or anesthetic complications? _____

Review of Systems: Have you experienced any of the following within the last 30 days? Circle all that apply.

Constitutional: Fever Chills Night Sweats Recent Weight Gain Recent Weight Loss Exercise Intolerance

Ears: Ringing in Ears Difficulty Hearing/Deafness Ear Pain

Eyes: Dry Eyes Irritation Wear Glasses Wear Contacts

Nose: Frequent Nosebleeds, Nose/Sinus Problems

Mouth/Throat: Sore Throat Bleeding Gums Snoring Dry Mouth Oral Abnormalities Mouth Ulcer Teeth Abnormalities/Dentures Mouth Breathing Hoarseness Dental Infections

Cardiovascular: Chest Pain w/ Exertion Arm Pain w/ Exertion Shortness of Breath When Walking Palpitations Shortness of Breath When Lying Down Swelling in Legs Known Heart Murmur Irregular Heart Beat Fainting

Respiratory: Cough Wheezing Shortness of Breath Coughing Up Blood Sleep Apnea

Gastrointestinal: Abdominal Pain Vomiting Change in Appetite Black or Tarry Stools Frequent Diarrhea Vomiting Blood Nausea Heartburn

Genitourinary: Urinary Loss of Control Difficulty Urinating Increased Urinary Frequency Hematuria Incomplete Emptying Burning with Urination Difficulty Starting Stream

Musculoskeletal: Muscle Aches/Stiff Muscle Weakness Arthralgia/Joint Pain Back Pain Swelling in Extremities

Integumentary: Abnormal Mole Jaundice Rash Itching Dry Skin Growths/Lesions Tattoos Masses

Neurologic: Loss of Consciousness Weakness Numbness Tingling Seizures Dizziness Migraines Restless Legs Frequent/Severe Headaches Problems w/ Speech Visual Change Balance Problems

Psychiatric: Depression Sleep Disturbances Restless Sleep Feeling Unsafe in Relationship Alcohol Abuse, Eating Disorder Anxiety Hallucinations

Endocrine: Fatigue Increased Thirst Hair Loss Increased Hair Growth Cold Intolerance Heat Intolerance

Hematology/Lymphatic: Bleeding Tendency Swollen Glands Night Sweats