Name:
DOB:
Chart:
Age:
Date:

New Patient/New Problem History Intake Form *(v. 1/2010)* *Southern Orthopaedic Surgeons, LLC*

PAST MEDICAL HISTORY

*Please check if **you** have **ever** had any of the following or check none:*

☐ NONE
☐ Diabetes
☐ Heart Disease/CAD
☐ High Blood Pressure
☐ Stroke/CVA/TIA
☐ Other:
☐ Blood Clots/DVT/PE
☐ Staph Infection/MRSA
☐ Emphysema/COPD
☐ Peptic Ulcer Disease
☐ Osteoporosis
☐ Rheum. Arthritis
☐ Lupus/SLE
☐ Fibromyalgia
☐ Asthma
☐ Hepatitis
☐ HIV/AIDS
☐ TB
☐ Kidney Disease
☐ Liver Disease
☐ Pneumonia
☐ Sleep Apnea
☐ Anxiety
☐ Depression
☐ Bipolar
☐ Chronic Pain

PAST SURGICAL HISTORY

*Please check if **you** have **ever** had any of the following or check none:*

☐ NONE
☐ Arthroscopy
☐ Total Joint
☐ Carpal Tunnel
☐ Other:
☐ Heart Catheterization
☐ Heart Bypass
☐ Pacemaker
☐ Hysterectomy
☐ Gastric Bypass
☐ Back/Neck Surgery
☐ Hernia Repair
☐ Tonsillectomy
☐ Rotator Cuff
☐ Cancer Surgery
☐ Vasectomy
☐ Tubal Ligation

CURRENT MEDICATIONS

*Please list the medications **you** are **currently** taking, check none or other options:*

☐ NONE ☐ SEE ATTACHED LIST ☐ SEE REVERSE FOR ADDITIONAL MEDS

DRUG ALLERGIES

*Please list the drug allergies that **you** have/had, check none or other options.*

☐ NONE KNOWN ☐ SEE ATTACHED LIST ☐ SEE REVERSE FOR MORE ALLERGIES

SOCIAL HISTORY

*Please answer the following questions about **you:***

TOBACCO USE: ☐ None ☐ Daily ☐ Occasional
ALCOHOL USE: ☐ None ☐ Daily ☐ Occasional
DRUG ABUSE: ☐ None ☐ Current ☐ Past
HOME STATUS: I live with: ☐ Mom, ☐ Dad, ☐ Siblings, ☐ Spouse, ☐ Partner, ☐ Children, ☐ Roommate, ☐ None, I live alone
I live in a: ☐ house, ☐ apartment, ☐ mobile home, ☐ assisted living facility, ☐ nursing home, ☐ shelter ☐ homeless

EMPLOYED? ☐ No ☐ Yes, position: _____
STUDENT? ☐ No ☐ Yes, school: _____
MARITAL STATUS? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Child

REVIEW OF SYSTEMS

*Please check if **you** currently have or recently had any of the following:*

Gen: ☐ Fever ☐ Chills ☐ Sweats ☐ Weight Loss ☐ Fatigue
Eyes: ☐ Glasses/Contacts ☐ Blind ☐ Blurred ☐ Itching
CV: ☐ Chest Pain ☐ Irregular Heart Beat ☐ Swollen Ankles
Pulm: ☐ Cough/Sneeze ☐ Wheezing ☐ Shortness of Breath
GI: ☐ Constipation ☐ Diarrhea ☐ Blood/black Stools
MS: ☐ Weakness ☐ Gait Problem ☐ Brace ☐ Aches
☐ Cane ☐ Walker ☐ Wheelchair ☐ Bed rest

GU: ☐ Problems voiding ☐ UTI/burning ☐ Heavy Menstruation
ENT: ☐ Hearing Loss ☐ Ringing ☐ Runny Nose ☐ Sore Throat
Skin: ☐ Rash ☐ Burn ☐ Itching ☐ Dry Skin ☐ Keloid
Neuro: ☐ Dizzy ☐ Tingling ☐ Burning ☐ Numb ☐ Lost Balance
Psych: ☐ Anxious ☐ Depression ☐ Suicidal Thoughts ☐ Rage
Endo: ☐ Hot Flashes ☐ Cold Flashes ☐ Hormone Imbalance
Heme: ☐ Free Bleeding ☐ Bruise Easily ☐ Lymphedema

FAMILY HISTORY

*Does anyone in your immediate **family** have or ever had any of the following:*

☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke/CVA/TIA ☐ DVT/PE ☐ Cancer ☐ TB ☐ HIV/AIDS ☐ Hepatitis

Reason for Visit _____ Date of Injury _____

When/Where did accident occur? _____

Referring\Primary Care Provider _____ Signed: _____ M.D.\P.A.

8CCL1

Name:
DOB:
Chart:
Age:
Date:

Southern Orthopaedic Surgeons L.L.C.

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JASON T. RANDALL, M.D.
R. LEE MURPHY, M.D.

PATIENT NAME

E-RX CONSENT

I agree that Southern Orthopaedic Surgeons, l.l.c. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

NOTICE OF PRIVACY PRACTICE

Southern Orthopaedic Surgeons, l.l.c. attempts to comply with all requirements pertaining to the release of your medical information. A copy of our privacy practices is posted in the waiting room of each office and a copy is available at the reception counter of each office upon request.

INSURANCE AUTHORIZATION AND RELEASE OF INFORMATION

I request that payment of authorized Medicare/Other Information Company benefits be made either to me or on my behalf to Southern Orthopaedic Surgeons, l.l.c. for any services or items furnished me by that physician/supplier. 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 for related services. I understand my signature requests that payment be made and authorizes release of medical information to pay the claim. If item 9 of the HCFA-1500 claim form is completed my signature authorizes releasing of information to the insurer or agency shown. In the event that payment is received from another source on medical charges for these services, I authorize application of the proceeds received form this source upon any other medical bill of mine or any member of my family for whose medical bill I would be legally responsible that has not been paid in full at the time of receipt of proceeds from this source, subject to the rules of coordination of benefits, if applicable. I further recognize that if payment is made direct to me by the insurance company, the amount received up to the amount of all medical bills for services requested is the property of Southern Orthopaedic Surgeons, l.l.c. and should be paid to them immediately.

STATEMENT OF FINANCIAL RESPONSIBILITY

I am responsible for all financial obligations of health services for the above patient, and for reimbursement and payment of claim from my insurance company. I understand that in Medicare/Other Insurance Company assigned cases the physician/supplier agrees to accept the charge determination of the Medicare/Other Insurance Company as the full charge and the patient is responsible only for the deductible, coinsurance and noncovered services. I further understand that the physician/supplier will attempt to collect assigned insurance benefits for a period of thirty to sixty days after the date of service at which time payment of the full amount due will be my responsibility. If for any reason the account should become delinquent, I agree to pay all collection costs including attorney fees.

ADDING COLLECTION AGENCY FEES

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

TELEPHONE CONSUMER PROTECTION ACT

You agree, in order for us to service your account, Southern Orthopaedic Surgeons, l.l.c., and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/ artificial voice messages and/or use of automatic dialing device, as applicable.

SIGNATURE DATE

Name:
DOB:
Chart:
Age:
Date:

Southern Orthopaedic Surgeons LLC.

MEDICAL RELEASE FORM

Patient Name: _____ **Chart #:** _____

Effective April 14, 2003 (due to federal guidelines under HIPAA) we are now required to have a release form signed by the patient before we can give out any medical or financial information to any person other than the patient.

Please list below the names, relationship, and phone numbers of any authorized individuals (spouse, family members, friends, caregivers, etc.) that we may discuss your medical or financial information with.

NAME	RELATIONSHIP	PHONE NUMBER
1.		
2.		
3.		

May we leave medical information on you "home" answering machine? ☐ **Yes** ☐ **No**

Signature of Patient / Parent **Date**

OR

If you do not want any of your medical or financial information discussed with anyone other than yourself please sign here.

Signature of Patient / Parent **Date**

The above information is private and confidential and will be placed in your medical chart. The information on this form will remain valid until we are notified otherwise.