Today's Date:_____ Chart #_____

PATIENT INFORMATION (please print – blue or black ink only)

Name:_____ Age:_____ Birth Date:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email Address:_____

Social Security #:_____ Primary Care Physician:_____

Pharmacy's Phone Number:_____ Store Number:_____ Location:_____

Employed? (circle one) Yes No **Full-time Student?** (circle one) Yes No

Employer:_____ Work Phone:_____Occupation:_____

Work Address:_____ City:_____ State:_____ Zip:_____

Marital Status (circle one) Single Married Divorced Widowed **Who referred you here?**_____

SPOUSE INFORMATON

Name:_____ Social Security Number:_____Birth Date:_____

Employer:_____ Work Phone:_____ Cell Phone:_____

Work Address:_____City:_____State:_____Zip:_____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name:_____ Relationship:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

INSURANCE INFORFMATION

Primary Insurance Co Name:_____ Group #: _____ID #_____

Address:_____City:_____State:_____Zip:_____

Policy Holder's Name: _____ Social Security Number:_____

Date of Birth:_____ Relation to Patient (circle one) Self Spouse Mother Father Other

Secondary Insurance Co Name:_____ Group #: _____ID #_____

Address:_____City:_____State:_____Zip:_____

Policy Holder's Name: _____ Social Security Number:_____

Date of Birth:_____ Relation to Patient (circle one) Self Spouse Mother Father Other

I authorize the release of any medical information necessary to process insurance claims. My signature also authorizes payment of medical benefits to the named provider for professional services rendered. I understand that I am financially responsible for all services rendered, that there is a $30 returned check fee and that 30% will be added to my balance if any account must be referred to an agency for collection.

_____ _____

(Patient's Signature) (Date)

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Chart #_____

History of Present Illness/Injury

Name:_____ Date:_____

Date of Birth:_____ Age:_____

Left / Right handed (circle one) Occupation:_____

Primary Care Physician:_____ Who referred you?_____

Did you go to the emergency room? Yes No Where?_____ When?_____

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 the 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.)*_____

_____

For this recent injury/illness, have you had any recent *(please circle)* : X-rays MRI CT Bone Scan

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Medical Record #:_____

Health History

Name:_____ **Email:**_____ **Date:**_____

DOB:_____ **Height:**_____ **Weight:**_____ ☐ **Male** ☐ **Female**

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
☐ Arterial fibrillation or erratic heartbeat
☐ Bladder problems
☐ Bleeding ulcers
☐ Blood clot
☐ Legs ☐ Lungs
☐ Cancer Type:_____
☐ Congestive heart failure
☐ Coronary artery disease
☐ Dental disease
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Epilepsy/Seizures
☐ Fibromyalgia
☐ Gout
☐ Hemophilia/Excessive bleeding
☐ Hepatitis
☐ High blood pressure/Hypertension
☐ High Cholesterol
☐ HIV or AIDS
☐ Infections _____
MRSA? ☐ Yes ☐ No
☐ Kidney Disease
☐ Osteoarthritis
☐ Osteoporosis
☐ Pneumonia
☐ Psychiatric Disorder
☐ Rheumatoid arthritis
☐ Sickle Cell
☐ Sleep apnea
☐ CPAP Machine
☐ Stroke (CVA)
☐ Thyroid disease
☐ Other not listed, explain
_____
_____

Surgical History

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

☐ **NO PAST SURGERY**
☐ Abdominal surgery
Type of Surgery:_____
☐ Aneurysm
☐ Angioplasty/Stents
☐ Artery bypass of arm or leg
☐ Bone/Joint surgery
Type of surgery: _____
☐ Breast Surgery
Type of Surgery:_____
☐ Cartoid surgery
☐ Cervical spine surgery
☐ Colon surgery
☐ Coronary bypass (CABG)
☐ Gastric bypass surgery
☐ Heart valve replacement
☐ Hysterectomy
☐ Lumbar Spine Surgery
☐ Pacemaker/Defibrillator
☐ Prostate surgery
☐ Other not listed, explain
_____
_____

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FAMILY HISTORY

Date:_____ Medical Record #:_____

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	☐ Cancer Relation:_____	☐ Hypertension Relation:_____	☐ Stroke Relation:_____
☐ Adverse Reaction to anesthesia Relation:_____	☐ Depression Relation:_____	☐ Osteoarthritis Relation:_____	☐ Other not listed, explain _____
☐ Bleeding disorders Relation:_____	☐ Diabetes Relation:_____	☐ Osteoporosis Relation:_____	_____
☐ Blood clots/Pulmonary embolism Relation:_____	☐ Heart disease Relation:_____	☐ Rheumatoid arthritis Relation:_____	_____

Social History

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widow/Widower

Hobbies:_____

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

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 allergy?_____

Tape allergy? ☐ Yes ☐ No

Current Medications

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

☐**NOT CURRENTLY TAKING MEDICATIONS**

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

NAME:_____ **DOB:** _____

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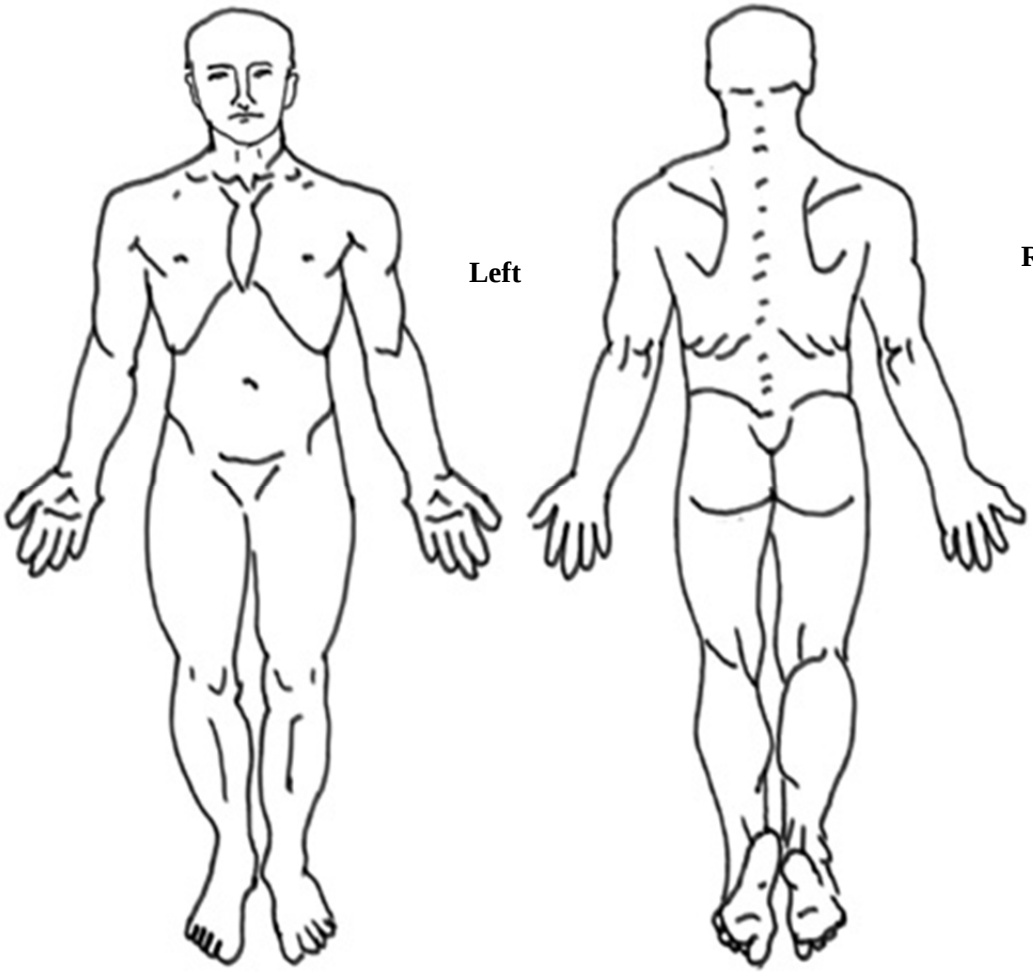
PAIN DRAWING

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_____ **Date of Birth:**_____

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The American Recovery and Reinvestment Act of 2009 require that we gather additional information from you about your background. Thank you for answering the following three questions:

1. Race

☐ American Indian or Alaskan Native ☐ Black, African American ☐ Native Hawaiian, Other Pacific Islander

☐ Asian ☐ White ☐ Hispanic or Latino

☐ Unknown ☐ Declined

2. Ethnicity

☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

☐ Declined ☐ Unknown

3. Primary Language

☐ English ☐ Spanish ☐ Other _____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORMS

I, _____, have been informed that a copy of Eastside Orthocare's Notice of Privacy Practices is posted on their website and in the office.

_____ _____
Signature Date

It is our policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail or cell phone. However, we will confirm appointments by telephone. Whenever returning phone calls and the answering machine picks up we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

I authorize Eastside Orthocare to contact me at the following places:

Home telephone	Yes ☐	No ☐
Cell phone/voice mail	Yes ☐	No ☐
Work telephone	Yes ☐	No ☐
Answering machine	Yes ☐	No ☐
Cell phone number	Yes ☐	No ☐

Please list names of people with whom we may discuss your medical care:

Spouse Name_____ Yes ☐ No ☐

Parent Name_____ Yes ☐ No ☐

Other Name_____ Yes ☐ No ☐

Please list names of people with whom we may discuss your financial information.

_____

_____

_____

_____ _____
Signature Date

THIS FORM IS TO BE COMPLETED ANNUALLY

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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 form the practice with 30 days' notice for noncompliance in the taking of their medications. In order to ensure compliance, Eastside Orthocare 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.
7. Eastside Orthocare will NOT refill prescriptions that have been lost or misplaced.
8. I must keep all appointments as recommended.
9. I will not give away, 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 Eastside Orthocare's 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 any prescriptions. My pharmacy's name and location is:_____

_____

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

I have read, understood 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 I have a right to a paper copy upon request or can obtain a copy on the Eastside Orthocare website at www.eastsideorthocarega.com and have the opportunity to ask questions and receive answers to my satisfaction.

Patient Name *(please print):*_____ Date of Birth:_____

Patient Signature:_____ Date:_____

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CONTROLLED SUBSTANCE AGREEMENT AND INFORMED COSENT FORM

In May of 2011Governor Nathan Deal signed into law SB36, 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 360.3.60) 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 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 mean 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 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 **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 **Narcotic Contract and Prescription Refill Policy**.

_____ _____

Signature Date

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AUTHORIZATION TO REQUEST A COPY OF MY MEDICAL RECORDS TO BE FORWARDED

Please read this page carefully, fill it in and sign it. This allows a copy of your medical records to be sent.

PATIENT INFORMATION:

Name:_____ Date of Birth:_____

Social Security Number:_____ Phone Number:_____

Address:_____

_____

CURRENT LOCATION OF YOUR RECORDS THAT YOU WANT COPIED:

Name of Physician or Group:_____

Address:_____

_____

Telephone Number:_____ Fax Number:_____

LOCATION TO SEND YOUR REOCRDS:

Name of Physician or Group:_____

Address:_____

_____

Telephone Number:_____ Fax Number:_____

INFORMATION TO COPY AND RELEASE:

☐ All Records
☐ Dates of treatment: _____ or _____
☐ Labs

This authorization is valid for 90days and may be revoked at any time in writing prior to the expiration date. I understand that my medical record may contain information in reference to psychiatric issues and/or HIV testing/treatment.

Patient Signature_____ **Date**_____