Carolina Musculoskeletal Institute, PA
Patient Information Form

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Age: ___ Sex: M or F (please circle one) SS#: _____-_____-_____

Mailing address: _____ Street address: _____ Apt #___ City: _____ State:___ Zip:_____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work: ( ) _____

Email address: _____

Employer/School: _____ Occupation: _____

Employer/School Address: _____ If you are a college student list home and school address

Name of Spouse: _____ DOB: _____ SS#: _____

Marital Status: M S W D (please circle one) Spouse's Employer: _____ Spouse Employer Phone #: ( )_____

In case of an emergency, please notify _____ Phone #: _____

Family/Primary Care Doctor: _____ **Referring Doctor**: _____

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Guarantor Information

Mailing Address: _____ City: _____ State: _____ Zip:_____ Phone_____

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

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

Mother's Employer: _____ Phone #: ( )_____

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

Father's Employer: _____ Phone #: ( ) _____

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Pharmacy Name: _____ **Address #:** _____ **Phone #:** _____

****

Primary Insurance: _____ ID #:_____ Grp #:_____

Insured Name: _____ Insured DOB: _____ Insured SSN#: _____

Secondary Insurance: _____ ID #:_____ Grp #:_____

Insured Name: _____ Insured DOB: _____ Insured SSN#: _____

Name of RESPONSIBLE party for the patient's bill: _____ DOB_____ SSN #_____
(Note: Must be self, parent, or legal guardian)

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ACCIDENT QUESTIONNAIRE

No Accident_____ **Auto Accident**_____ **Work Related**_____ **Other Accident**_____

Date of the Injury:_____ Where did Injury Occur?_____

Do you have an Attorney/Lawyer? YES or No (Please circle one) Name_____ **Address**_____ **Phone**_____

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HOME HEALTH/SKILLED NURSING FACILITY QUESTIONNAIRE

If you are currently receiving Home Health or residing in a skilled nursing facility (nursing home or rehabilitation facility), that entity may be responsible to pay for the services you receive today. It is important that we have the correct information on file for this reason.

Are you currently receiving Home Health? ____ **yes** ____ **no**

If yes, which agency is providing your 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 EACH SECTION

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 you are unable to pay your co-payment or co-insurance amounts, your appointment may be rescheduled. 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 practice are not met, my account could be referred to an outside collection agency for further collection activity.

If the patient no shows, or cancels their appointment more than three times, their treating physician reserves the right to discharge the patient from the practice.

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 Carolina Musculoskeletal Institute, PA to release any medical information to any referring physician, other health care providers, hospitals and medical facilities, and to my insurance carriers 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 the practice of medicine is not an exact science and that diagnosis and treatment may involve risk I furthermore, authorize Carolina Musculoskeletal Institute, PA to release any of my medical or financial information to the following people.

Name_____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

Patient or Responsible Party Signature: _____ **Date:**_____

III. Assignment of Insurance Benefits: I hereby assign and authorize payment to Carolina Musculoskeletal Institute, PA 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 this form is to be considered as valid as an original. I hereby authorize Carolina Musculoskeletal Institute, PA 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. Copies of Medical Records/Images): To obtain copies of your medical record there is an administrative charge of $15.00 plus.65cents for each page. To obtain a CD with copies of your images, i.e. to X-Ray, CT, MRI, etc. a charge of $25.00 will be assessed.

V. Drug Screen Policy: The physicians of CMI may order a random urine drug-screening test at their discretion in the following cases: patients receiving pain medication for 90 days or more, and for patients that are referred to CMI from any Pain Management Physician.

Patient or Responsible Party Signature: _____ **Date:**_____

VI. Privacy Practices: I acknowledge receipt of Carolina Musculoskeletal Institute, P.A. Notice of Privacy Practices.

Patient or Responsible Party Signature: _____ **Date:** _____

VII. Telephone Messages: Messages left for your physician or his nurse will be addressed in a timely manner as follows:

1. Calls received before 3:00 pm will be returned by the close of business that day.
2. Calls received after 3:00 pm may not be returned until the next business day.
3. If you are in the office for an appointment and need refills on your medication or you need a work/school excuse, please inform your doctor or nurse at that the time of service.

Patient or Responsible Party Signature: _____ **Date:**_____

Carolina Musculoskeletal Institute, PA
Medical History

Date: _____/_____/_____ Patient Name _____ DOB _____

Patient Age _____ Ht_____ Wt_____ Referring Physician_____

Your reason for today's visit – What specific body part is causing the problem? (Please specify right or left) _____

_____

Accident Date/Onset of Problem _____ How did the accident or injury occur?_____

Have you seen another physician for this problem? YES / NO_____ Is there an Attorney involved? _____

Have imaging studies been done for this problem, X-Ray, MRI, CT Scan, Bone Scan When: _____Where:_____

Do you have your x-rays with you? YES / NO

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

	Yourself	Family Members		Yourself	Family Members
Alcoholism/Substance Abuse	Y or N	Y or N	High Cholesterol	Y or N	Y or N
Anemia	Y or N	Y or N	Hypo/Hyperthyroidism	Y or N	Y or N
Anxiety/Depression	Y or N	Y or N	Lupus	Y or N	Y or N
Asthma	Y or N	Y or N	Migraines	Y or N	Y or N
Atrial Fibrillation (type in comments)	Y or N	Y or N	Polio	Y or N	Y or N
Bleeding Tendencies	Y or N	Y or N	Rheumatoid Arthritis	Y or N	Y or N
Cancer (type in comments)	Y or N	Y or N	Sickle Cell Disease	Y or N	Y or N
COPD or Emphysema	Y or N	Y or N	Stomach Ulcers	Y or N	Y or N
Coronary Artery Disease	Y or N	Y or N	Stroke	Y or N	Y or N
Sleep Apnea	Y or N	Y or N	Tuberculosis	Y or N	Y or N
Diabetes	Y or N	Y or N	HIV/AIDS	Y or N	Y or N
Epilepsy	Y or N	Y or N	Kidney Disease	Y or N	Y or N
GERD	Y or N	Y or N	Glaucoma	Y or N	Y or N
Hepatitis	Y or N	Y or N	Organ Transplant	Y or N	Y or N
High Blood Pressure	Y or N	Y or N	Seasonal/Metal Allergies	Y or N	Y or N

Comments/Other_____

_____

If you answered yes to Atrial Fibrillation and/or Cancer, please indicate what type:_____

_____

Current Medications: (Also, include over the counter medicines.)

Name Dose How Often?

1._____

2._____

3._____

4._____

Medical History (continued)

Patient Name _____

Have you ever taken cortisone pills? **Yes or No** / If yes, when? _____ How long? _____
Have you ever taken cortisone shots? **Yes or No** / If yes, how many? _____ Why? _____

Current Treatment for pain and symptoms:

Have you had Physical Therapy treatment? **Yes or No** / If yes, How many visits? _____ Where? _____

Have you had instructional home exercises prescribe by your physician? **Yes or No** / If yes, how many weeks_____

Have you been treated or currently being treated by a Chiropractor? **Yes or No** / If yes, how many visits or weeks _____

Have you applied heat or ice to the problem area? **Yes or No**

Past Treatment for pain and symptoms:

Have you tried over the counter medications? **(Ex: Tylenol, Advil, Motrin, Aleve) for your problem area?** _____

Have you had pain management for any chronic conditions? If yes, _____

Allergies: Ex: Penicillin Hives

Name of medication and allergic reaction	Name of medication and allergic reactio
1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Surgical History:

Name of Procedure	Year	Name of Procedure	Year
1. _____		4. _____	
2. _____		5. _____	
3. _____		6. _____	

Social History: Please answer all questions completely.

Tobacco Use: **Yes or No** Type_____ Packs per day _____ How long_____

Alcohol Use: **Yes or No** Type_____ Amount per week _____

Drug Use: **Yes or No** Type _____ Amount per week _____

Gender Identity and LGBTQ

Gender Identity:
- ☐ Identify as Male
- ☐ Identify as Female
- ☐ Transgender Male/Female-to-Male (FTM)
- ☐ Transgender Female/Male-to-Female (MTF)
- ☐ Gender non-conforming (neither exclusively female or male)
- ☐ Additional gender category/other, please identify _____
- ☐ Choose not to disclose

Assigned sex at birth: ☐ Male ☐ Female ☐ Choose not to disclose ☐ Unknown

Pronouns: ☐ he/him ☐ she/her ☐ they/them

First name used: _____

Sexual Orientation:
- ☐ Bisexual
- ☐ Lesbian, gay or homosexual
- ☐ Straight or heterosexual
- ☐ Something else, please describe _____
- ☐ Choose not to disclose

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APPOINTMENT CANCELLATION / NO SHOW

Please note: The suite number has changed for Podiatry location

It is the goal of Carolina Musculoskeletal Institute to provide quality medical care to our patients in a timely manner. In order to do so we ask that you read and sign this Appointment Cancellation/No Show Policy. This policy enables us to better utilize available appointments for our patients in need of medical treatment.

If you are unable to keep your scheduled appointment or need to reschedule your appointment, please contact our office 24 hours in advance. By cancelling or rescheduling your appointment early allows us to reallocate this time to other patients who are in need of medical treatment. If you miss an appointment (no- show) it will be recorded in your medical record. The second no- show appointment will result in a letter being mailed to you stating that you have missed two appointments and the third no- show appointment, reschedule or cancelled appointment will result in your dismissal from the practice.

While we understand that situations may arise preventing you from arriving for your scheduled appointment on time, we do ask that you contact our office if you are going to be late. If you are more than 15 minutes late and do not notify our office your appointment may be cancelled.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have. We thank you in advance for your cooperation.

By signing below you acknowledge that you have read and understand the Cancellation/No Show Policy of Carolina Musculoskeletal Institute, PA

_____ _____

Patient Signature Date

_____

Print Name

_____

Witness