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**: _____

****

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 #: ( ) _____

****

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)

****

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_____

****

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
410 University Parkway
Rheumatology Suite 1400
Podiatry Suite 2600
Pain Management 2600
Aiken, SC 29801
(803) 644-4264 • Fax (803) 617-1984
www.CMI.md

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

CAROLINA
MUSCULOSKELETAL
INSTITUTE

New Patient Intake Form

Your completed intake paperwork helps our physicians and other providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk or call if you have any question on how to complete any section on this form.

Patient Information

Today's Date: _____ Your name: _____

Date of Birth: _____

Referring Physician: _____ Primary Care Physician: _____

Preferred Phone: _____ May we leave a message at this number? ☐Yes ☐No

Preferred Pharmacy: _____ Phone Number of Pharmacy: _____

Pharmacy Address: _____

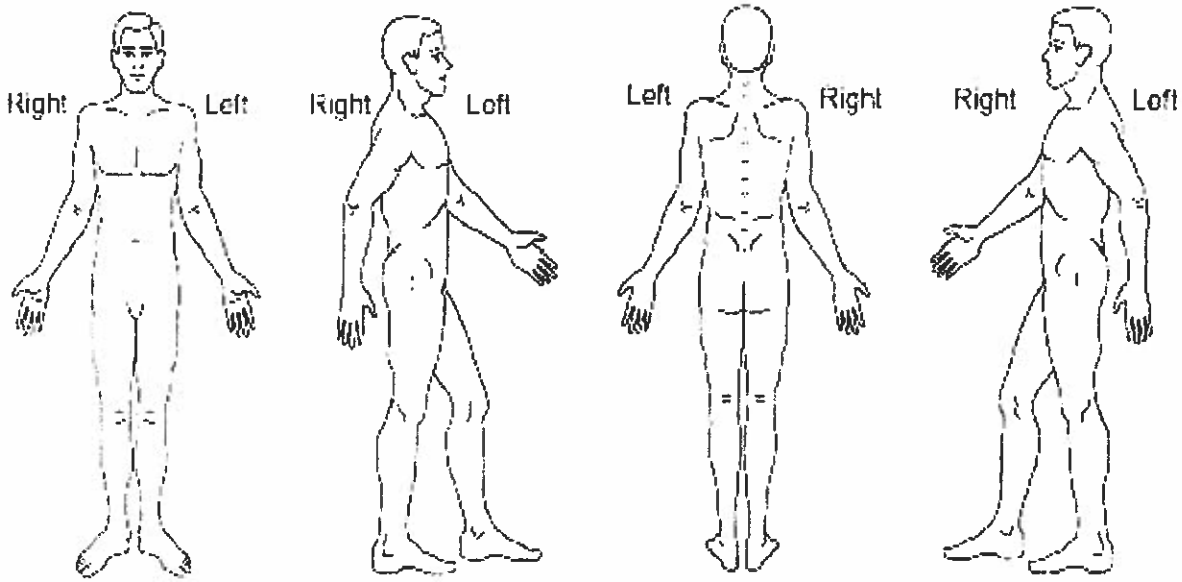
Pain History

Chief Complaint (Reason for your visit today)? _____

Does this pain radiate? If so where? _____

Please list any additional areas of pain: _____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Pain Description

Approximately, when did this pain begin? _____

What caused your current pain episode? _____

Describe the character of your pain (eg: dull, stabbing, throbbing, etc):

_____

What time of day is your pain at its worst? _____

What factors worsen or affect your pain? _____

What factors relieve your pain? _____

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now _____ The best it gets _____ The worst it gets _____

Please mark all of the following treatments you have had for pain relief: ☑

☐ Spine Surgery ☐ Chiropractor ☐ Physical Therapy ☐ Brace Support ☐ Hot/Cold packs

For PHYSICAL THERAPY, please provide:
Start Date: _____ **End Date:** _____ **Number of Sessions:** _____

For CHIROPRACTIC CARE, please provide:
Start Date: _____ **End Date:** _____ **Number of Sessions:** _____

MEDICATION CLASSES TRIED:

☐NSAIDS (ibuprofen, naproxen (Aleve), meloxicam (Mobic), Motrin, diclofenac (Voltaren), etc.)

☐ Acetaminophen (Tylenol)

☐Steroids

☐Opioids/Narcotics (hydrocodone, oxycodone, tramadol, morphine, etc.)

☐Anti-convulsants (gabapentin (Neurontin), pregabalin (Lyrica), etc.)

☐Muscle relaxants (baclofen, Flexeril, Robaxin, Skelaxin, Zanaflex)

☐Neuropathic pain modulators (amitriptyline, nortriptyline, duloxetine (Cymbalta), venlafaxine (Effexor), etc.)

☐ Topicals (Lidoderm patch, Voltaren gel, Flector patch, etc.)

Please list the names of other Pain Physicians you have seen in the past?

_____

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist	☐ Neurosurgeon	☐ Psychiatrist/Psychologist
☐ Chiropractor	☐ Orthopedic Surgeon	☐ Rheumatologist
☐ Internist	☐ Physical Therapist	☐ Neurologist

Past Medical History

Please list any medical conditions you are currently being treated for:

1) _____

2) _____

3) _____

4) _____

Past Surgical History

Please list any surgical procedures you have had done in the past including date:

1) _____

2) _____

3) _____

4) _____

☐ I have **NEVER** had any surgical procedures performed.

Social History

Occupation:_____ When was the last time you worked? _____

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

Are you currently under worker's compensation? ☐ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

Alcohol Use:

☐ Social Use ☐ Daily use of alcohol ☐ Never ☐ History of alcoholism ☐ Current alcoholism

Tobacco Use:

☐ Current user ☐ Former user ☐ Never used

☐ Packs per day? _____ ☐ How many years? _____ ☐ Quit Date: _____

Illegal Drug Use:

☐ Denies any illegal drug use ☐ Currently uses illegal drugs ☐ Formerly used illegal drugs (not currently

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

Current Medications

Are you currently taking any blood thinners or anti-coagulants? ☐ YES ☐ No

If YES, which ones? Plavix ☐ Coumadin ☐ Lovenox ☐ Other _____