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 #:** ______________

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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? ______________________________

Carolina Musculoskeletal Institute, PA
410 University Parkway
Rheumatology Suite 1400 Fax Number (803) 617-1984
Podiatry Suite 2600 Fax Number (803) 649-0042
Pain Management 2600 Fax Number (803) 649-3333
Aiken, SC 29801
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

A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D.____________ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D.___________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D.___________ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the D.___________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D.___________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the D.___________ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Carolina Musculoskeletal Institute – Rheumatology

BONE DENSITY QUESTIONNAIRE

Name:______________________________ Age:______________ Race:______________

Referring Doctor:______________________ Height:____________ Weight:______ lbs

1. Are you postmenopausal? ____Yes____NO What age did you have menopause?________
2. Did you have a hysterectomy? ____Yes____NO
3. Are you now on or ever been on hormone replacement therapy? ____Yes____NO
   If no, please explain____________________________________.
4. Excluding pregnancy, have you ever missed a menstrual period for longer than one year before age 45? ____Yes____NO
5. Do you currently or have a history of smoking more than one pack of cigarettes per day for more than five years? ____Yes____NO
6. Do you have a history of anorexia? ____Yes____NO
7. Have you ever been diagnosed with gastrointestinal disease? ____Yes____NO
8. Have you ever been diagnosed with a thyroid disorder? ____Yes____NO
9. Do you take medication for thyroid replacement? ____Yes____NO

10v. Have you ever been diagnosed with a parathyroid disorder? ____Yes____NO

11. Do you have a family history of broken bones after age of 45 not resulting from a accident? (stress fracture, fall) ____Yes____NO

12v. Have you lost more than one inch height? ____Yes____NO

13. Have you received medication therapy for seizures (Dilantin) for at least three months or longer? ____Yes____NO
14. Have you received for longer than three months heparin therapy? ____Yes____NO

15v. Have you taken prednisone 7.5 mg a day for longer than for longer than three months? ____Yes____NO

16. Do you take calcium supplements? ____Yes____NO If yes, how much?____________

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Carolina Musculoskeletal Institute – Rheumatology
BONE DENSITY QUESTIONNAIRE

17. Do you excercise regularly? ____Yes____NO If yes, what do you do?________________

18. Do you have more than five servings of caffeine per day? ____Yes____NO

19. Do you have any other health problem? ____Yes____NO If yes, what? __________
____

20. Are you currently taking medication for osteoporosis or osteopenia? ____Yes____NO
How long?____________ Medication Name:________________________

21v. Have you been diagnosed by x-ray with:

21a. Osteoporosis? ____Yes____NO

21b. Osteopenia? ____Yes____NO

21c. Vertebral Fracture? ____Yes____NO If yes, please explain?
____

21d. Do you have a history of back pain? ____Yes____NO

Signature: X____ Date: X________________