

**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: \_\_\_\_\_  
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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**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:** \_\_\_\_\_

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**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. 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: \_\_\_\_\_

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

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? \_\_\_\_\_

**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
Cancer (type in comments)	Y or N	Y or N	Sickle Cell Disease	Y or N	Y or N
Bleeding Tendencies	Y or N	Y or N	Rheumatoid Arthritis	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	_____				

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

Name	Dose	How Often?	Name	Dose	How Often?
1. _____			3. _____		
2. _____			4. _____		

**Allergies: Ex: Penicillin Hives**

Name of medication and allergic reaction	Name of medication and allergic reaction
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 \_\_\_\_\_

**Carolina Musculoskeletal Institute, PA**  
410 University Parkway  
(803) 644-4264  
Pain Management 2600 Fax Number (803) 649-3333  
Podiatry Suite 2600 Fax Number (803) 649-0042  
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