PATIENT REGISTRATION FORM

Southeastern Sports Medicine

PARDEE UNC HEALTH CARE

Patient Name (first, middle, last): _____

Date of Birth: _____ Age: _____ Male Female Social Security #: _____ Marital Status: _____

Mailing Address: _____ City: _____ State: ____ Zip Code: _____

Physical Address (if diff from mailing): _____ City: _____ State: ____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Referred By: _____

Patient's School: _____ Patient's Coach: _____

Patient's Employer: _____ Work Phone: _____

Employer's Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Emergency Relationship: _____

Emergency Phone: _____

RESPONSIBLE PARTY/PARENT/GUARDIAN: Person responsible for payment today and after insurance payment (if any).

Name: _____ Date of Birth: _____ SS #: _____

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

Phone Number: _____

INSURANCE INFORMATION: Do you have school insurance? Yes No

Primary Insurance Company: _____ Subscriber's Name: _____

Subscriber's SS #: _____ DOB: _____ Employer: _____

Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____ Subscriber's Name: _____

Subscriber's SS #: _____ DOB: _____ Employer: _____

Policy Number: _____ Group Number: _____

PRIMARY CARE PHYSICIAN INFORMATION

Primary Care Physician: _____

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

Phone Number: _____ Do you want records sent to your PCP? ☐ Yes ☐ No

MEDICAL CONSENT: I consent to the examination, treatment and procedures which may be performed during the office visit, including emergency treatment considered necessary by the physician. If an invasive procedure is necessary, a specific consent form will be discussed with me at that time.

FINANCIAL POLICY AND CONSENT: Payment of deductibles and copayments is expected at the time of service. I understand that I am responsible for the balance owed to Margaret R. Pardee Memorial Hospital (Pardee) after my insurance carrier(s) have been billed. I agree to pay for all services rendered to me without regard to any benefit limitations imposed by any insurance carrier, unless prohibited by law or contract. I consent to Pardee's use and disclosure of my health information to any person or organization that is legally or contractually responsible for payment of my bills for the services I received. I also consent to Pardee's disclosure of my health information to attending and consulting providers for billing purposes.

Signature: _____ Date: _____

PATIENT NAME_____DOB_____DATE_____

REASON FOR VISIT

REASON FOR VISIT: _____

When did this problem begin (include date/time if accident and location: _____

Describe how injury occurred: _____

Have you had this problem before? YES NO Current Height: _____ Current Weight: _____

PLEASE CHECK IF YOU HAVE EVER BEEN TREATED BY: _____Dr. Maxwell _____Dr. Motley _____Dr. Rudins _____Dr. Jones _____ Dr. Phelps _____Dr. Kersten _____Dr. Das

REVIEW OF SYSTEMS

Circle all that apply to you.

Constitutional
Chills
Fatigue
Fever
Malaise
Night sweats
Weakness
Weight gain
Weight loss

HEENT
Blurred Vision
Double Vision
Dysphagia
Ear drainage
Facial pain
Headache
Hearing loss
Hoarseness
Nasal Congestion
Ringing in the ears
Vertigo
Vision Loss

Respiratory
Chest pain
Cough
Dyspnea
Recent infections
Known TB exposure
Wheezing

Cardiovascular
Chest pain
Cyanosis
Heart murmur
Leg Swelling
Syncope
Irregular heartbeat/palpitations

Gastrointestinal
Abdominal Pain
Constipation
Black tarry stools
Diarrhea
Heartburn
Jaundice
Loss of appetite
Nausea
Vomiting

Genitourinary
Dysuria
Frequent urination
Hematuria
Urge incontinence
Urinary incontinence

Metabolic/Endocrine
Cold intolerant
Hair loss
Heat Intolerant

Neurological
Difficulty walking
Dizziness
Poor coordination
Memory loss
Muscle weakness
Paresthesia
Seizures
Tremors

Psychiatric
Anxiety
Depression
Insomnia

Integumentary
Contact allergy
Itchy skin
Rash
Skin infections
Skin lesions

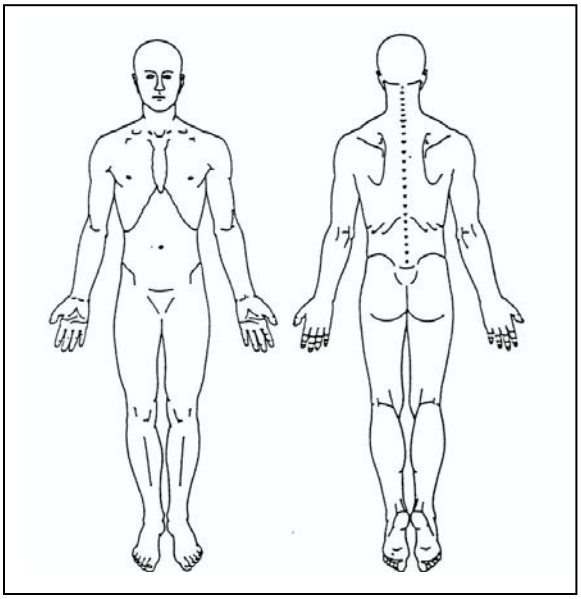
Musculoskeletal
Back Pain
Bone/Joint Symptoms
Myalgia
Muscle Weakness
Neck Stiffness
Rheumatologic Manifestation
Arthritis

Hematologic
Bleeding
Bruising

Immunological
Asthma
Bee Sting allergies
Contact dermatitis
Environmental allergies
Food allergies
Seasonal allergies

Using the diagram please indicate where your current pain is located.

DRAW YOUR PAIN:
Numbness ====
Burning XXXX
Stabbing ////
Pins and Needles OOOO



PATIENT NAME_____DOB_____DATE_____

PATIENT PHARMACY INFORMATION

Pharmacy Name: _____ Phone Number: _____

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

MEDICATION LIST		
TYPE OF MEDICATION	**DOSAGE**	**REASON FOR MEDICATION**

WORK INFORMATION

What is your job? _____

What are the physical requirements of your job? _____

Is your problem job-related? Y N

If yes, have you notified your employer? Y N

If yes, does your supervisor or boss support you in your treatment? Y N

If yes, have you been offered alternate light duty? Y N

If out of work, how long?

SOCIAL HISTORY

Do you use tobacco ☐YES ☐ NO If yes, how much per day? _____ Do you drink alcohol? ☐YES ☐ NO If yes, how much per day? _____

Do you drink caffeinated beverages? ☐YES ☐ NO If yes how much per day? _____

Please check if you have a history of ☐ excessive alcohol use ☐ excessive prescription drug use ☐ illegal drug use

If so, when? What type of substance?

PAST TREATMENTS FOR CURRENT PROBLEM:

_____

_____

ALLERGIES		SURGERIES	
TYPE	**REACTION**	**TYPE**	**YEAR**

CURRENT/PAST MEDICAL CONDITIONS	FAMILY HISTORY OF ILLNESS	
	TYPE	**RELATIVE**

PATIENT NAME_____DOB_____DATE_____

HIPAA DISCLOSURE INFORMATION: (who we can release to or who can request your medical information)

Who is filling this out?: _____ Patient _____ Guardian

The physician/practice may use or disclose the following protected health information: □ The entire medical record or □Other:_____

_____

The following protected health information is specifically excepted from disclosure: □ Nothing or List any health information you do not wish to be disclosed:_____

Disclosure to:_____ any health care provider or facility Others:_____

_____ Spouse Name: _____

_____ Children Name(s): _____

MEDICATION/PRESCRIPTION REFILL POLICY

- Please call 24 to 48 hours BEFORE you are out of medication. There will be no exceptions.
- Please leave the following information for your refill. Patient name, Physician name, medication name, and preferred pharmacy.
- Refills require 48 hours. Please check with your pharmacy before calling back AFTER 48 hours.
- No early Refills. No refills on holidays, weekends, or after hours. NO EXCEPTIONS.
- Lost or Stolen medications will not be refilled. NO EXCEPTIONS

XRAY POLICY

If you are a New Patient or being referred by another doctor you need to make sure ALL of your X-Rays are in our office or you are bringing them with you to your appointment.
If you're scheduled for an MRI you will also need to make sure your films are delivered here or you need to pick up a copy and bring them with you to your appointment. It is your responsibility to make sure your films are here. If you do not check and your films are not here you will not be seen that day.

Explanation/Findings of X-rays and MRIs

To assist your physician in fully explaining the results of your diagnostic x-rays or MRIs, your physician may show you your films. This may occur in an open area and may be overheard by others. A private review may be scheduled if you wish. Please let the medical assistant aware if you have any questions or concerns.

PAYMENT OF ACCOUNTS

INSURANCE CARD INFORMATION:
If you do not have your insurance cards available at the time of your appointment, you will be considered self-pay. Once we get a copy of your insurance card and your policy number in our system we can then bill your insurance for all visits.

NO INSURANCE:
If you do not have insurance, payment is expected at time of service. A minimum of $200.00, excluding any x-rays, injections, or procedures is expected at check in. We realize that injuries are unexpected and money is not always available. If the full amount cannot be paid at time of service, then prior arrangements must be made with the Patient Accounts Department.
We do not accept or file liability insurance. If you have a claim which you are filing with liability, we will be happy to give you a receipt showing your payment. You may file this for your re-imbursement.

INSURED PATIENTS:
Payment of deductibles and co-payments is expected at the time of service. Cash, Check, MasterCard and Visa are acceptable methods of payment. Insurance claims for each service date will be submitted to your insurance company. Please be aware that depending on the procedure performed (x-rays, labs or injections), you may receive statements and insurance billing from Margaret R. Pardee Memorial Hospital and/or Southeastern Sports Medicine. Please note if you have a deductible with your insurance these procedures could be applied toward it.

I have read and accept the above medication, x-ray, and payment of accounts policies.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

THANK YOU SOUTHEASTERN SPORTS MEDICINE