



****PLEASE COMPLETE ALL SECTIONS****

ACCOUNT NUMBER	
<input type="checkbox"/> Becton	<input type="checkbox"/> New Patient
<input type="checkbox"/> Kerins	<input type="checkbox"/> ER
<input type="checkbox"/> Crosland	<input type="checkbox"/> Hospital
<input type="checkbox"/> Goodrich	<input type="checkbox"/> Update
<input type="checkbox"/> Ruark	<input type="checkbox"/> Personal
<input type="checkbox"/> Wellband	<input type="checkbox"/> W/Comp
	<input type="checkbox"/> Private Pay

Medical Doctor _____ Telephone# _____

Cardiologist _____ Telephone# _____

Referred By _____

Referral Address _____ Appt Time _____ Work-In _____ Date _____

HAVE YOU EVER SEEN ONE OF OUR DOCTORS? _____ IF SO, WHO? _____ WHEN? _____

COMPLAINT _____ DATE OF FIRST SYMPTOMS _____

PATIENT'S FULL NAME _____ MR _____ MRS _____ MISS _____ NAME USED _____

MAILING ADDRESS _____ PHONE _____

STREET ADDRESS _____ CELL _____

CITY _____ COUNTY _____ STATE _____ ZIP _____

PATIENT'S DATE OF BIRTH _____ AGE _____ SS# _____

MARRIED _____ SINGLE _____ WIDOWED _____ DIVORCED _____ SEPARATED _____ RACE _____ SEX _____

WHO WILL PAY THIS ACCOUNT _____

PATIENT EMPLOYED BY _____ PHONE _____

BUSINESS ADDRESS _____

SPOUSE/PARENT NAME _____ DOB _____ SS# _____

SPOUSE/PARENT EMPLOYED BY _____ PHONE _____

BUSINESS ADDRESS _____

LOCAL FRIEND OR RELATIVE (NOT LIVING WITH YOU):

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ PHONE _____

ALLERGIES TO MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES? YES _____ NO _____
(If yes, please list name of medicine and type of reaction)

MEDICAL PROBLEMS, IF ANY _____

LIST MEDICATIONS CURRENTLY TAKING: _____

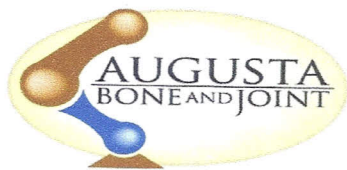
INSURANCE—PLEASE BRING INSURANCE CARDS TO FRONT DESK FOR COPYING.

SUBSCRIBER/RELATIONSHIP _____
(If different from patient, relationship of subscriber to patient)

SUBSCRIBER SS# _____ DOB _____

I hereby authorize and consent to such examinations and treatments by AUGUSTA ORTHOPAEDIC CLINIC, P.A., AUGUSTA, GA, as may be ordered or requested by the doctor in charge of this case and agree to pay all fees and charges for such treatment. I agree to pay all charges shown by statements promptly, unless credit arrangements are made. I am responsible for all charge regardless of insurance coverage, or denial of worker's compensation benefits. The above information is for purpose of extending credit and is warranted to be true. I hereby authorize release of medical information to my insurance company and assign any applicable benefits to this practice. I understand that I am responsible to pay any unpaid balances.

DATE: _____ X _____
Signature of patient or responsible party and authorization to release information



AUGUSTA BONE AND JOINT

Orthopaedic History (Page 1)

Name _____

Today's Date _____ SS# _____ DOB _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Current problem is the result of a (n): Check all that apply

- Car Accident
 Work Accident
 Accident
 Other

Family History

Member	Alive	Deceased	Age	Health status or cause of death
Grandparents (mom's)	A	D		
Grandparents (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Social History

Work in the Home Employed (occupation _____)
 Student
 Daycare
 Retired

Single
 Married
 Divorced
 Separated
 Widowed

Children?
 No
 Yes # _____

Do you live alone?
 No
 Yes _____

Exercise?
 Daily
 Weekly
 Monthly
 Rarely
 Never

What type of exercise? _____

History of substance abuse?
 No
 Yes
 What? _____

Smoke currently?
 No
 Yes
 _____ Packs per day for _____ years.

Quit smoking?
 This year
 >1 year
 >5 years
 >10 years

Previously smoked _____ packs per day for _____ years.

Drink alcohol?
 Dailey
 1-2 X/week
 1-2 X/month
 1-2 X/year

Patient Signature : _____ Date: _____



AUGUSTA BONE AND JOINT

Orthopaedic History (PAGE 2)

Name _____ Date _____

SS# _____ DOB _____

PAST MEDICAL HISTORY

SURGERIES/HOSPITALIZATIONS	YEAR	COMPLICATIONS

Have you ever had general anesthesia? NO YES
 Have any problems with anesthesia? NO YES

MEDICATION	Dose	Reason for Medication	Side Effects

ALLERGIES:

Are all immunizations up to date? Yes No If no, which immunizations are due ? _____

Review of Systems

Are you currently having or have you had problems with your:

	Circle	Describe all YES response	Treating physician
Eyes		_____	_____
Ears, Nose, Throat	NO YES	_____	_____
Lungs, Breathing	NO YES	_____	_____
Heart Problems	NO YES	_____	_____
Digestion	NO YES	_____	_____
Bowel movement	NO YES	_____	_____
Bladder problems	NO YES	_____	_____
Kidney problems	NO YES	_____	_____
Diabetes	NO YES	_____	_____
High blood pressure	NO YES	_____	_____
Bleeding problems	NO YES	_____	_____
Balance problems	NO YES	_____	_____
Numbness/tingling	NO YES	_____	_____
Blackout/fainting	NO YES	_____	_____
Psychological problems	NO YES	_____	_____
AIDS	NO YES	_____	_____
Cancer	NO YES	_____	_____
Arthritis	NO YES	_____	_____
Polio	NO YES	_____	_____
TB	NO YES	_____	_____
Epilepsy	NO YES	_____	_____

Patient Signature: _____ Date _____

Reviewed By: _____ MD Date: _____