Valdosta Orthopedic Associates

3527 North Valdosta Road
Valdosta, GA 31602

Welcome to our office!

Name: _____ Date of Birth: _____

Address: _____City: _____ St: _____Zip: _____

SSN (required): _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Preference: Home Cell Work

Email: _____ May we email? Yes No

Preferred Language: _____Race:_____ Ethnicity: _____

Primary Care Physician: _____ Phone: _____

Would you like your primary care physician to receive a copy of your visit notes? Yes No

How did you hear about our office? _____

Insurance Information

You must provide a copy of your insurance card or you will be billed at the self pay rate.

Primary Insurance Company: _____ Policy Number: _____

Secondary Insurance Company: _____ Policy Number: _____

Guarantor's Information (for patients under 18 years old)

Name: _____ Date of Birth: _____

Address: _____City: _____ St: _____Zip: _____

SSN (required): _____ Phone: _____ Alt Phone: _____

Relationship to Patient: _____ Phone: _____ Is this your emergency contact: Yes No

Did your injury happen on the job? Yes No

If yes, on what date did the injury occur: _____

Did you report the injury to your employer? Yes No Date Reported: _____

Is your injury the result of a motor vehicle accident? Yes No State Accident Occurred: _____

Our office will file insurance for all reimbursable services, to your primary, secondary, and tertiary insurance carriers. **Please remember you are responsible for all deductibles, co-pays, and non-covered service amounts.** We must have copies of your insurance cards.

Assignment of Benefits: I hereby authorize insurance benefits to be paid directly to Valdosta Orthopedic Associates. **I understand I am responsible for any amounts not covered by my policies nor paid by my insurance companies.**

Release of Information: I authorize Valdosta Orthopedic Associates to release any information requested by my insurance company to insure prompt, accurate payment of my claims. I certify the information furnished here is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Insured Signature: _____ Date: _____

Fees, Forms, and No Checks Policy

Due to appointment waiting lists and booked schedules, no-show fees will be assessed if at least 24 hour notice is not given prior to missing an appointment. Fees are as follows:

$25 fee for office visit and physical therapy no-show

$50 fee for physical therapy evaluation no-show

$50 fee for Nerve Conduction Study/EMG no-show

$100 fee for Procedure Room no-show

$100 fee for MRI no-show

All forms that need to be completed must be paid for prior to being completed! Please allow 5-7 business days for forms to be completed and ready for pick-up or mailing.

$10 charge for Family Medical Leave Act (FMLA) and parking permit forms

$20 charge for insurance, disability, or other miscellaneous forms

Please note: due to the rising cost for non sufficient fund (NSF) checks, Valdosta Orthopedic Associates will no longer accept personal checks as payment for services or deposits. We can only accept certified checks, cash, debit or credit cards (Visa, MasterCard, Discover, or Care Credit), and money orders. We DO NOT accept American Express.

Patient Signature: _____ Date: _____

or

Parent/Caregiver Signature: _____ Date: _____

Valdosta Orthopedic Associates

HIPPA Release

I understand that under the Health Information Portability and Accountability Act of 1996 (HIPPA), I have certain rights to the privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan, and direct treatment and follow-up amount multiple healthcare providers who may be involved in that treatment, directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I give permission for Valdosta Orthopedic Associates to discuss my healthcare information with the following people:

✓ _____

Name Relationship Date

✓ _____

Name Relationship Date

✓ _____

Name Relationship Date

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

or

Parent/Caregiver Signature: _____ Date: _____

******* **THIS FORM WILL REMAIN ACTIVE UNTIL REVOKED BY ABOVE STATED PATIENT*******

Valdosta Orthopedic Associates

Orthopedic Health History

Date of Visit: _____

History of Chief Complaint

What body part are you being seen for today? ☐ Right ☐ Left ☐ Bilateral _____

Please explain your reason for today's visit: _____

How did it start?_____ When? _____

Was this caused by an injury? ☐ Yes ☐ No If yes, what is the date of injury?_____

Have you had any ☐ x-rays, ☐ MRI, ☐ CT If yes, when?_____ Where? _____

Have you attempted any previous treatment? ☐ Injection ☐ Physical Therapy ☐ Surgery

☐ Other _____Date_____

Vitals

Pain Scale (0 – no pain, 10 – worse pain): 0 1 2 3 4 5 6 7 8 9 10

Medications

List all medications you are currently taking. Please include the dosage. ☐ None ☐ See attached list

_____ _____

_____ _____

_____ _____

Allergies

List allergies and reactions: ☐ None ☐ Latex ☐ Tape ☐ Iodine/Betadine ☐ Contrast Dye ☐ Egg

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Family History

Please tell us about any family members who have or have had major health problems: ☐ Unknown/Adopted

Mother: ☐ Alive ☐ Deceased ☐ No current problems or disability

Health Problems: _____

Father: ☐ Alive ☐ Deceased ☐ No current problems or disability

Health Problems: _____

Siblings: ☐ Brother ☐ Sister ☐ Alive ☐ Deceased ☐ No current problems or disability

Health Problems: _____

Social History

Smoking Status: ☐ Never Smoker ☐ Former Smoker ☐ Current Every Day Smoker

☐ Current Some Day Smoker ☐ Smoker – current status unknown ☐ Unknown if ever smoked

How much do you smoke?_____ cigarettes per day _____ packs per day _____ packs per week

Has smoked for _____ years

Chewing tobacco? ☐ None ☐ _____ per day ☐ _____ per week

Illicit Drugs: _____

Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

How often do you drink more than 4 to 5 drinks? ☐ None ☐ Weekly ☐ Monthly

Do you have an advanced directive (living will)? ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Hand Dominance: ☐ Right ☐ Left ☐ Bilateral

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Are you currently employed? ☐ Yes ☐ No ☐ Employer: _____

Occupation: _____

Are you currently pregnant? ☐ Yes ☐ No ☐ Unsure

Is this a work-related injury? ☐ Yes ☐ No

Is this a motor vehicle related injury? ☐ Yes ☐ No

If you were injured, is litigation ongoing? ☐ Yes ☐ No ☐ Attorney:_____

Patient's Care Team

Current Primary Care Physician: _____Referred By: _____

Patient's Pharmacy

Preferred Pharmacy: _____ Phone #: _____

Secondary Pharmacy:_____ Phone #: _____

Surgical History

Please check if you have had any of these surgeries in the past:

☐ None

☐ Ankle Surgery
☐ Appendectomy
☐ Back Surgery
☐ Breast Surgery
☐ Coronary Artery Bypass Graft
☐ Carpal Tunnel Release
☐ Cesarean Section
☐ Defibrillator
☐ Elbow Surgery
☐ Foot Surgery
☐ Gallbladder Surgery
☐ Gastric Bypass
☐ Hand Surgery
☐ Heart Surgery
☐ Hernia Repair
☐ Hip Surgery
☐ Hysterectomy
☐ Knee Surgery
☐ Neck Surgery
☐ Pacemaker
☐ Shoulder Surgery
☐ Spine Surgery
☐ Thyroidectomy
☐ Tonsillectomy
☐ Joint Replacement of: _____
☐ Bone Surgery of: _____
☐ Other: _____
☐ Other: _____
☐ Other: _____

Past Medical History

☐ AIDS/HIV
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Blood Clotting Disorder
☐ Blood Thinners
☐ Cancer:_____
☐ COPD
☐ Depression/Anxiety
☐ Diabetes
☐ Dialysis
☐ DVT/Phlebitis
☐ Fibromyalgia
☐ GERD
☐ GI Bleed
☐ Gout
☐ Heart Disease
☐ Hepatitis, Type:_____
☐ Hypertension:
☐ Kidney Disease
☐ Liver Disease
☐ Migraine Headaches
☐ Osteoarthritis
☐ Rheumatoid Arthritis
☐ Seizures
☐ Stroke
☐ Thyroid Disease
☐ Ulcers
☐ Other:_____
☐ Other: _____
☐ Other: _____
☐ Other: _____
☐ Other: _____
☐ Other: _____
☐ Other: _____
☐ Other: _____
☐ Other: _____

Review of Symptoms

Have you experienced any of these symptoms recently? Please mark yes or no.

Reported by: ☐ Patient ☐ Parent ☐ Caregiver

Yes	No	
		Constitutional
☐	☐	fever
☐	☐	night sweats
☐	☐	significant weight gain:_____ lbs
☐	☐	significant weight loss:_____ lbs
		Eyes
☐	☐	vision change
		Ears, Nose, Mouth, Throat
☐	☐	difficulty hearing
☐	☐	nose problems
☐	☐	sinus problems
		Cardiovascular
☐	☐	chest pain
☐	☐	palpitations
		Respiratory
☐	☐	cough
☐	☐	shortness of breath
☐	☐	coughing up blood
		Gastrointestinal
☐	☐	abdominal pain
☐	☐	vomiting
☐	☐	diarrhea

Yes	No	
		Genitourinary
☐	☐	incontinence
☐	☐	difficulty urinating
		Integumentary
☐	☐	rashes
		Neurologic
☐	☐	loss of consciousness
☐	☐	weakness
☐	☐	numbness
☐	☐	dizziness
☐	☐	frequent or severe headaches
		Endocrine
☐	☐	fatigue
		Hematologic/Lymphatic
☐	☐	swollen glands
		Allergic/Immunologic
☐	☐	runny nose
☐	☐	itching
☐	☐	hives
☐	☐	frequent sneezing

Patient Signature: _____Date: _____

Parent/Caregiver Signature: _____Date: _____

Parent/Caregiver Printed Name: _____

Provider Signature: _____Date: _____

Valdosta Orthopedic Associates

Bone Health Risk Assessment

Name: _____ Date of Birth: _____

If you are 50 years or older, please complete the following assessment:

1. Have you had a fracture or broken bone as an adult? Yes No
2. Have you taken prednisone or other steroid for greater than 3 months? Yes No

If you answered yes to both of these questions, it is recommended that patients over 50 years old who have experienced a fragility fracture or are at high risk for fracture are assessed by Valdosta Orthopedic Associates' Bone Health Clinic to ensure optimal bone health and reduce risk for a primary or secondary fracture.

For women aged 65 and older or men aged 70 or older, have you had a baseline bone density scan (DEXA) since starting Medicare? Yes No

If yes, where was the scan performed? _____ Date: _____