Orthopaedic Specialist

East Tennessee Spine &

2815 West Andrew Johnson Hwy.
Morristown, Tennessee 37814-3216

Please complete the following so that we may accurately record your information:

Name:

_____

Address:

_____

City: _____ State: _____ Zip: _____

Phone- Home: _____ Cell: _____ Work: _____

Date of Birth: _____/_____/_____

Social Security: _____

Primary Care Physician: _____ Referred By: _____

Emergency Contact: _____ Phone Number: _____

Patient Employment

( ) Employed ( ) Retired ( ) Other _____

Employer: _____ Phone Number: _____

Financial Information

Responsible for Account: _____SSN: _____

Relationship: _____ Address: _____

Phone _____ Employer: _____Phone: _____

I hereby certify that the above information is true and accurate to the best of my ability.

Responsible Party Signature: _____ Date:_____

Responsible Party: _____ (Printed)

Name: _____ **Ht:** ____ **Wt:** _____ **Sex: M/F**

Primary Care: _____ **Date of Birth:** _____

ALLERGIES: _____

☐ I have no known allergies.

PATIENT MEDICAL HISTORY: Check **ALL** that applies ☐ I have no known medical history.

Heart Disease	Heart Attack		Pacemaker		Angina		Heart Failure		Hypertension			
Lung Disease	Asthma		Bronchitis		Pneumonia		COPD		Emphysema		TB	
Liver Disease	Liver Failure		Cirrhosis		Hepatitis							
Kidney Disease	Kidney Failure		Dialysis		Kidney Stones		UTI		Prostatitis			
Thyroid Disease	Hypothyroid		Hyperthyroid		Other:							
GI Disease	Ulcers		Gastric Reflux		Gastritis		Hiatal Hernia		Chron's			
Diabetes	Taking Medication		Insulin		Diet Controlled		Type II					
Psych Disorder	Depression		Anxiety		Sleep Apnea		Other:					
Neuro Disorder	Epilepsy		Polio		RSD		Multiple Sclerosis		Cerebral Palsy			
Blood Transfusion	When:		Why:									
Blood Disease	Anemia		HIV		Hepatitis A		Hepatitis B		Hepatitis C			
Cancer	Type:		Year Diagnosed:		Still Being Treated: YES/NO				Year Remission/Cured:			
Other Diseases:												

☐ I give ETSOS permission to access my RX history. Pharmacy Name: _____

List Medications if we do not have permission to access your RX:

_____

_____

Surgical history:

_____

_____

Marital Status: _____ **Number of Children:** _____

Smoker: _____ **If yes, packs per day?** ___ **How many years?** ___ **Quit, When?** ____

Drinker: _____ **If yes, how much?** _____ **Quit, When?** _____

Substance User: _____ **Substance Used?** _____, _____, _____. **Quit, When?** _____

Disabled: Yes/No Disability: _____ **When?** _____

Family Diseases: (Grandparents, Parents, Siblings):

_____

_____

Review of Systems: Current Problems (Circle the following that apply, or if NONE, please check box)

☐ **None of these current problems apply to me.**

General: **Fever Chills Fatigue Weight Loss Weight Gain Poor Appetite**

HEENT: **Stuffy Runny Nose Sore Throat Earache Nose Bleed Visual Changes**

Cardiac: **Chest Pain Tightness Pressure**

Pulmonary: **Cough Shortness of Breath Wheezing**

GI: **Nausea Heartburn Cramps Constipation Diarrhea Blood in Stool**

GU: **Pain Increased Frequency Blood Odor Burning**

Neuro: **Headaches Numbness/Tingling Shaking Loss of Balance**

Psychiatric: **Anxiety Depression**

Please Fill Out Form **Completely**

Name:_____ Date:_____

Primary Care Provider:_____

What are you being seen for today? What hurts you? RIGHT or LEFT?_____

Is your pain getting WORSE / NO CHANGE / BETTER? How long has this hurt you?_____

Please Explain_____

_____

Have you had x-rays for this problem?_____

Where and when?_____

What is your pain level today? 1 2 3 4 5 6 7 8 9 10

What is your pain level on a bad day? 1 2 3 4 5 6 7 8 9 10

What is your pain level on a good day? 1 2 3 4 5 6 7 8 9 10

How would you describe your pain? Aching / Deep / Throbbing / Sharp / Comes and goes / 24-7 / Numbness and tingling Burning / Swelling

What medications are you taking for this problem? (**Circle** all that apply)

Tylenol (acetaminophen)	Celebrex (celecoxib)	Nabumetone (Relafen)	Meloxicam (Mobic)	Diflunisal (dolobid)
Ibuprofen (advil, motrin)	Indomethacin (Indocin)	Oxaprozin (Daypro)	Salsalate	Ketoprofen (orudis)
Diclofenac sodium (cataflam)	Voltaren (Arthrotec)	Etodolac (lodine)	Sulindac (clinoril)	Piroxicam (feldene)
Naproxen (Naprosyn/aleve)	Narcotics			

Have you had injections of steroid (cortisone)? Yes / No How many?_____ Did it help? Yes / No

Have you had gel injections (Synvisc, Rooster comb)? Yes / No How many?_____ Did it help? Yes / No

Have you had physical therapy? Yes / No Where?_____ Did it help? Yes / No

Does your pain……

Limit your daily activities? Yes / No Affect your lifestyle? Yes / No swelling? Yes / No

Disturb your sleep? Yes / No Prevent you from exercising? Yes/ No Limping? Yes / No

Affect your ability to work? Yes / No Have you tried to lose weight? Yes / No Difficulty with lifting? Yes / No

Difficulty with stairs? Yes / No Make walking painful? Yes / No

Have you had surgery for this problem? Yes or No. Are you glad you had the surgery? Yes or No.

Percent Improvement since surgery: 0 10 20 30 40 50 60 70 80 90 100

If not satisfied, why not? _____

CIRCLE ANY THAT APPLY:

Joint pains	Unsteady gait	Dizziness
Joint swelling	Numbness	Headaches
Joint stiffness	Tingling	Tremors

IS IT RELATED TO: Job (work related) ☐ Car Accident ☐ Neither ☐

USING THE FOLLOWING SYMBOLS, MARK THE LOCATION(S) OF YOUR SYMPTOMS ON THE DIAGRAM:

RIGHT **LEFT**

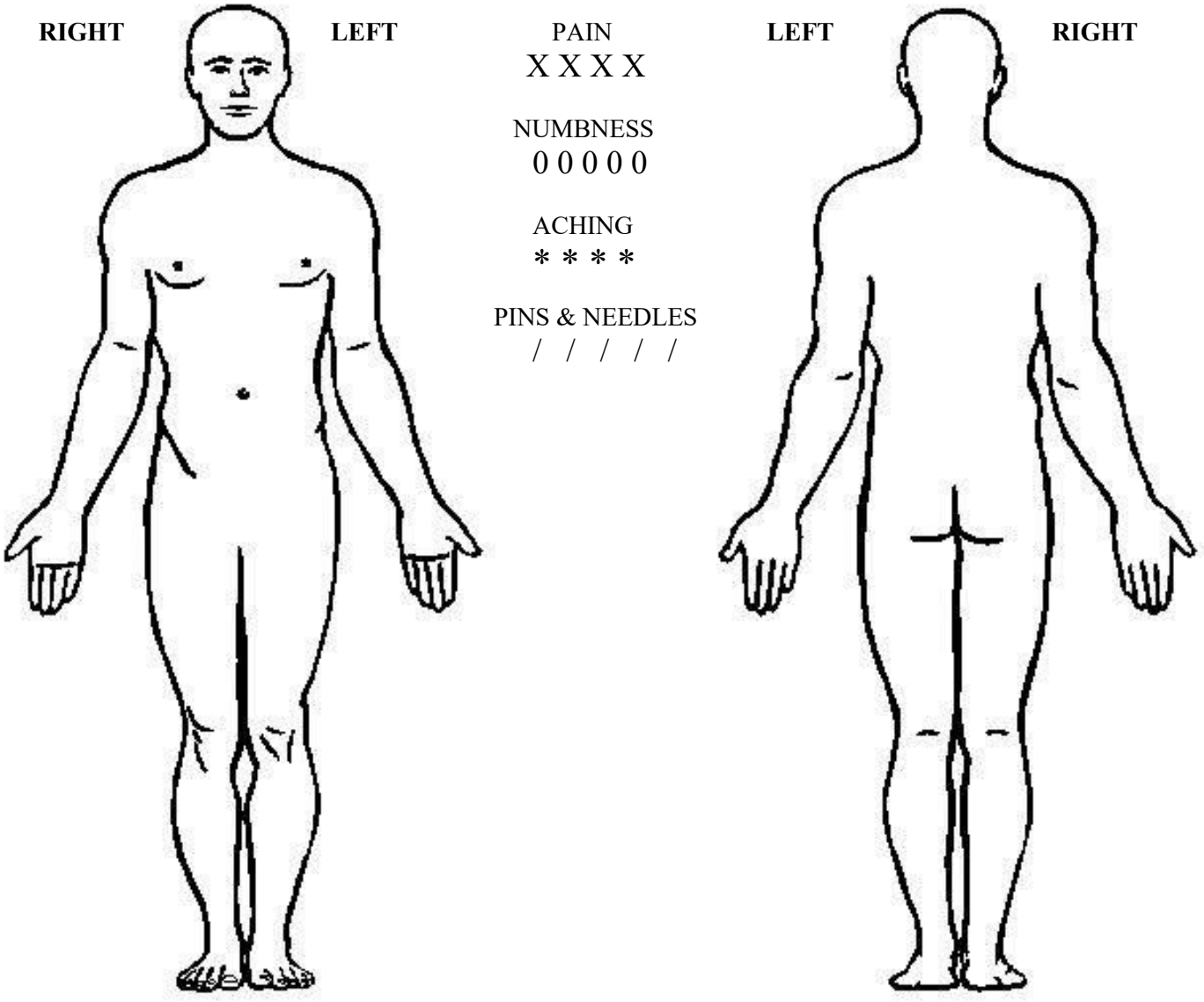
PAIN
X X X X

NUMBNESS
0 0 0 0 0

ACHING
* * * *

PINS & NEEDLES
/ / / / /

LEFT **RIGHT**



For a neck problem, what % of your pain is _____ % neck and _____ % arm (100% total)

For a back problem, what % of your pain is _____ % back and _____ % leg (100% total)

INSURANCE AUTHORIZATION AND ASSIGNMENT INFORMATION

I hereby authorize ETSOS to furnish pertinent information to my insurance carrier(s) and referring/consulting physicians concerning my illness, injury, or treatment. I assign payment of benefits directly to the physician for any medical services received by me or by my dependent. I understand that insurance coverage and benefits vary according to the policy and I agree to be responsible. In the event that the services I receive are experimental, investigational, or non-covered services, in or out of network, I understand that I will be held responsible for payment. I have the right to request reconsideration of a determination of non-payment. I understand that I will be responsible for all physician, facility, and ancillary charges, as well as any other related expenses. I understand that I will be responsible for non-covered charges, I will be responsible for timely payment of services(s), collection fees at 35% charge, attorney fees and any court costs if necessary. THIS AUTHORIZATION IS IN EFFECT FOR ALL FUTURE CLAIMS.

MEDICAL CONSENT RELEASE FORM

_____ give East Tennessee Spine & Orthopaedic Specialists permission to call my home, cell, or work numbers for appointment reminders and leave a message if needed. I will be considerate and call to cancel or reschedule my appointment at least 24 hours before my appointment time.

I give my consent to release medical information (verbally or written) to the person listed below.

Name _____ Relationship _____ Phone _____

Name_____ Relationship _____ Phone _____

I HAVE RECEIVED A COPY OF "NOTICE OF PRIVACY PRACTICES AND INDIVIDUAL RIGHTS"

******SIGNATURE**_____ **DATE**_____

Form must be completely filled out

East Tennessee Spine & Orthopaedic Specialists

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for East Tennessee Spine & Orthopaedic Specialists to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by East Tennessee Spine & Orthopaedic Specialists describes such uses and disclosures more completely).

I have the right to review the Notice of Privacy Practices prior to signing this consent. East Tennessee Spine & Orthopaedic Specialists reserves the right to revise its Notice of Privacy Practice at any time. A revised Notice of Privacy Practices may be obtained by verbal request at East Tennessee Spine & Orthopaedic Specialists.

With this consent, East Tennessee Spine & Orthopaedic Specialists may call or text my home or other alternative location and leave a message on voicemail or in person in referenced any items that assist the practice in carrying out TPO, such as reminders, insurance items (any financial data regarding my patient account), and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, East Tennessee Spine & Orthopaedic Specialists may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder letters or cards and patient statements as long as they are marked “Personal and Confidential”.

With this consent, East Tennessee Spine & Orthopaedic Specialists may fax or e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder letters or cards and patient statements. I have the right to request that East Tennessee Spine & Orthopaedic Specialists restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow East Tennessee Spine & Orthopaedic Specialists to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, East Tennessee Spine & Orthopaedic Specialists may decline to provide treatment to me.

Signed by: _____ _____ _____

Signature or Patient of Legal Guardian | Date | Relationship to Patient

_____ _____

Print Patient’s Name | Print Name of Legal Guardian, if applicable