ORTHOPAEDICS OF ATLANTA, P.C.

Dr. W. Joseph Absi, M.D.

INITIAL PATIENT ASSESSMENT AND HISTORY

Name_____ **Age**_____ **Occupation**_____

Thank you for choosing us to assist in your medical care.

Please fill out this form completely to assist us with your visit.

Handedness ❑ Right ❑ Left

Employer_____

Pending Litigation ❑ Yes ❑ No

History of Symptoms

1. Who **referred you to this office?**

_____

2. Who is your **family (medical) physician?**

_____

3. **Where are you hurting?** _____

_____

4. When did your symptoms begin? _____

5. Was this due to an injury?
   ❑ Yes ❑ Auto related ❑ Job related ❑ No
   If yes, date of injury _____

6. **Describe injury** _____

_____

_____

7. Did you go to the Emergency Room? ❑ Yes ❑ No
   When _____ Where _____

8. Have you seen **another physician** for this condition? ❑ Yes ❑ No
   If yes, whom? _____

_____

9. **How did it start?** (check the appropriate box)
   ❑ Suddenly ❑ Fall ❑ Injured during sports
   ❑ Gradually ❑ Bending ❑ No apparent cause
   ❑ Lifting ❑ Pulling
   ❑ Twisting ❑ Injured at work

10. Does any activity make it **worse?**
    ❑ Exercise (during) ❑ Standing ❑ Sneezing
    ❑ Exercise (after) ❑ Walking ❑ Bending backward
    ❑ Sitting ❑ Coughing ❑ Bending forward
    ❑ Other _____

11. Does any activity make it **better?**
    ❑ Lying down ❑ Manipulation ❑ Exercises in physical therapy
    ❑ Sitting ❑ Pain pill ❑ Muscle relaxant pills
    ❑ Standing ❑ Injections for pain ❑ Aspirin or anti-inflammatory pills
    ❑ Walking ❑ Nothing

Medical History

12. Have you had **surgery for this problem?** ❑ Yes ❑ No
    Number of times ____ Dates _____

_____

13. Have you had **other surgeries?** (appendix, gall bladder, etc.)

_____

_____

_____

14. Do you now have or have you ever had **any of the following conditions?**
    ❑ Stomach Ulcers ❑ Bowel or Bladder problem
    ❑ GERD (specify: _____)
    ❑ Diabetes ❑ High blood pressure
    ❑ Arthritis/Gout ❑ Heart
    ❑ Asthma (specify: _____)
    ❑ Aids/HIV ❑ Epilepsy
    ❑ Cancer of_____ ❑ Weight loss
    ❑ Other (please specify) _____

15. Is there a possibility that you may be pregnant?
    ❑ Yes ❑ No

16. What **medications** are you *currently* taking?

MEDICATIONS	DOSAGE	FOR WHAT PROBLEM

17. Do you have any medication **allergies?** ❑ Yes ❑ No
    Please list _____

_____

18. Do you **smoke?** ❑ Yes ❑ No How much?_____

19. Do you **drink** alcoholic beverages? ❑ Yes ❑ No
    How much? _____

20. Do you have any additional information that would be helpful in understanding your problem?

_____

_____

_____

_____

_____

_____

Review of Systems

21. Do you have a history of any of the following?

Abnormal Bleeding	❑ Yes	❑ No
Chest Pain	❑ Yes	❑ No
Fever/Chills	❑ Yes	❑ No
Numbness Hands/Feet	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No
Stomach Pain	❑ Yes	❑ No
Weight Loss	❑ Yes	❑ No
Muscle Weakness	❑ Yes	❑ No

_____ _____

PATIENT SIGNATURE DATE

INS. CODE: _____ ACCOUNT NUMBER: _____ KEYED BY: _____

NEW PATIENT INFORMATION

PATIENT

Last Name _____

First Name _____ MI _____

Street Address _____

City _____ State _____ Zip _____

Home Phone ( ) _____

Social Security No. _____

Employer _____

Work Phone _____

Date of Birth _____ Age _____

Sex: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Divorced

Occupation _____

Have you been treated by Dr. Absi in the past?

❑ Yes ❑ No When? _____

Who referred you to this office? _____

❑ Dr. _____ Give Name

❑ Hospital _____ Give Name

❑ Yellow Pages ❑ Family Member ❑ Other

Date of Illness/Injury _____

Give details of accident/injury _____

GUARANTOR / INSURANCE INFORMATION

Primary Ins. Co. _____

Group No. _____

Subscriber No. _____

Policyholder _____

Policyholder Address _____

Date of Birth _____

SS # _____

Employer _____

Work Phone _____

Home Phone _____

Secondary Ins. Co. _____

Group No. _____

Subscriber No. _____

Policyholder _____

Policyholder Address _____

Date of Birth _____

SS # _____

Employer _____

Work Phone _____

Home Phone _____

Responsible Party:
Who is responsible for billing? Name _____ Phone _____

Address _____

WORKERS' COMPENSATION (Complete only if work related injury.)

Employer Name _____

Employer's Address _____

Supervisor Name _____

Date of Injury _____

Verified By _____

Work Phone _____

W/C Ins. Co. Carrier _____

Address _____

How Accident Occurred _____

ASSIGNMENT OF BENEFITS / MEDICAL RECORDS RELEASE / FINANCIAL RESPONSIBILITY

I hereby assign all medical/surgical benefits to which I am entitled, including major medical, Medicare, private insurance, and any other health plan to this practice. This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure payment and to complete disability forms presented by me.

We are committed to provide you with the best possible care. We are proud that our fees are comparable to others in our community. Whenever possible, the patient must pay all office visits, at the time of service, unless you have insurance with Medicare, Medicaid, HMO, or PPO with the proper referral. Regardless of the type of plan you have, you are responsible for deductibles, co-insurances, co-pays and any medical service not covered in your insurance policy at time of service.

We must emphasize that as medical care providers, our financial relationship is with you, not your insurance company. If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. Financial counseling is available. We are here to help you.

Signed _____ Date _____

DR. W. JOSEPH ABSI.M.D.

NOTICE TO PATIENTS- HIPAA CONSENT

The (H.I.P.A.A) Health Insurance Portability & Accountability Act of 1996 has created a new national standard to protect individuals' medical records & other personal health information.

You will only be required to give this consent one time unless you have revoked the consent between treatments. The revocation must be in writing.

By signing this agreement you are allowing us to disclose pertinent health care information to other providers, labs, hospitals, your insurance company, our billing clearing house as needed to obtain payment for our services and to aid in your healthcare as deemed by your physician. We will make reasonable efforts to limit the use, disclosure of, and requests to the minimum necessary to accomplish the individual purpose. If you decline to sign this agreement, the physician may refuse to provide treatment, as he cannot bill for his services without the necessary information provided by your medical records.

We **WILL NOT** sell your name to a mailing list, disclose information to an employment decisions or disclose information for eligibility for life insurance without signed authorization from you written on their letterhead. All requests for the release of medical records **must be** in writing.

You have the right to view our privacy policies upon request prior to signing this consent.

_____ Date _____

Signature of Patient/Guardian

_____

Print Name

3886 Princeton Lake Way, Ste 100 • Atlanta, GA. 30331 • (404) 768-1133 • FAX (404) 574-1725

Orthopaedics Of Atlanta, P.C.

W. Joseph Absi, M.D.

INSURANCE AUTHORIZATION

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE:

I, the undersigned, authorized payment of medical benefits to Orthopaedics of Atlanta, P.C., for any services furnished to me by the physician practice named above. I understand that I am financially responsible for any amounts not covered by my insurance contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment, or supplies provided by me. This information will be used for the purpose of evaluating and administering claims of benefits.

SIGNATURE: _____ DATE: _____

MEDICARE/MEDICAID SIGNATURE ON FILE:

I request that payment of authorized Medicare/Medicaid benefits be made to Orthopaedics of Atlanta, P.C., on my behalf for any services furnished to me by the physician practice named above. I authorize any holder of information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

SIGNATURE: _____ DATE: _____

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