

1. INTRODUCTION

Welcome to Southern Orthopedic Specialists, P.A. This pamphlet provides information that we hope will foster a pleasant and effective relationship between patient and physician and contribute to better understanding of how to serve you, the patient. If you have further questions, please do not hesitate to ask any member of our staff.

2. APPOINTMENTS

- A. If you are unable to keep your appointment please call the office and cancel it at least 24 hours in advance.
- B. The physicians and staff work hard to see patients on time. If you have to wait to be seen it is for an unavoidable reason. We are obliged to see emergencies and patients referred on an urgent basis by other physicians. Some patients require an unexpected amount of time due to unforeseen complications or problems. For these reasons, we are occasionally behind schedule. We ask for your understanding in those situations.
- C. Please complete the information sheet and medical history forms and bring it with you at the time of your first visit.

3. CHARGES

- A. Charges made for surgical procedures cover post-op office visits for a period of time determined by your insurance company, varying from 7 to 90 days. The surgery charges do not cover x-rays or cast changes made relative to the surgery.
- B. Charges for fracture treatment cover all office visits related to the fracture for a period of time determined by your insurance company, varying from 7 to 90 days. The fracture charges do not cover x-rays or cast changes.
- C. If it is determined that you are going to need to have surgery, our office will call your insurance company to determine what portion of the surgery your insurance will cover. Someone from our insurance department will then contact you and inform you of approximately how much you will owe the physician. Patients will be expected to pay their portion of an elective surgery prior to it being performed. Self-pay patients will also be responsible for paying a portion of their surgery in advance as well.

4. BILLING

- A. Statements are sent out at the end of each month.
- B. A statement will be sent to you even though your insurance company may be responsible for the payment. This allows you to keep track of how well your insurance company is serving you. Your statement will reflect the date on which your charges are filed to your insurance company. This will give you some idea as to how long it takes your insurance company to process your claim.

5. TREATMENT POLICIES

- A. Most orthopedic problems can be treated by non-surgical means and every such means available that is indicated in the treatment of your particular illness will be exercised before surgical treatment is recommended.
- B. Satisfactory results are not guaranteed for any type of surgical procedure as there is not a single operation that is 100% successful. Results of surgery are affected by genetics, life style and patient cooperation as well as surgeon skill. Medicine is also not an exact science. If surgery is recommended to you, the probability of a successful outcome will be explained to you. If you do not understand the reasons for the surgical procedure, its chances of success, or its possible complications, please ask us. Also, do not hesitate to ask us the charge for a particular operation if you desire that information.
- C. An adult must accompany all patients under 18 years of age.

6. MEDICATIONS

Narcotic medications are prescribed only for patients in severe pain. Narcotic medications are not kept in the office. Requests for prescription refills should be made before 3:00p.m. Requests received after 3:00p.m. will be addressed the next business day. We do not prescribe prescriptions after business hours, on weekends or holidays.

7. MEDICAL RECORDS

- A. Medical records will be sent to your insurance companies, attorneys, other physicians, etc. upon request of that person in writing.
- B. The patient must sign a statement authorizing the release of information before this information can be sent to anyone.

8. X-RAYS

X-rays that are taken in our offices are part of the patient's original medical record. Therefore, the original x-ray may not leave this office. If you would like a copy of your x-rays, you must request them at least one day in advance, so our x-ray technician will have time to prepare the copies. There is a charge of \$5 per sheet of film. Our x-ray technicians try to put as many images as possible on one sheet of film to keep the cost to you at a minimum. Patients must sign a statement authorizing the release of the x-ray since it is part of the medical record.

9. DME

In an effort to serve you faster and more thoroughly we have an on site durable medical equipment department. For those patients that are in need of a brace and have a qualifying insurance policy we carry the most commonly used orthopedic braces. To insure that you are getting a quality brace we have a no return policy on all of our DME.

FINANCIAL PAYMENT POLICY

In our effort to provide quality health care to our community, it is important to establish a clear credit policy to avoid any misunderstandings. Our primary responsibility is to help our patients experience good health, and we wish to spend our time and energy toward that end. All accounts are payable at the time of service. We accept VISA, MASTERCARD, DISCOVER and AMERICAN EXPRESS for your convenience. Payment arrangements are available through our trained Insurance Specialists in accordance with our Credit Guidelines. If you feel that you will not be able to pay your bill, please inform one of our receptionists so that a representative in the billing department can make payment arrangements.

As a service to our patients, we will bill your primary and secondary insurance carriers provided you supply the name, address, group and ID# and the name of the policyholder. If you prefer to bill your own insurance, we will furnish you with a complete itemized statement. We do not negotiate disputed claims with your insurance company. If you have questions regarding your coverage or any special arrangements, please contact your insurance carrier directly.

All patients will be required to sign an insurance release form that allows us to file their insurance to their carriers. Patients will also be required to sign a statement stating that they have read our Financial Payment Policy and will be responsible for their bill.

A. Patient Responsibility, with Insurance

1. Co-pays are due at the time of visit
2. Deductibles must be paid at the time of service, if not paid prior to your visit.
3. For surgery, arrangements for patient responsibility must be made in advance. Of course emergency surgery will be handled in manner applicable to the need.
4. All insurance payments will be monitored closely to assist you in experiencing the highest possible payout under your plan.
5. Portions not paid by your insurance carrier will become your responsibility.

B. Patient Responsibility, without Insurance

1. Payment is due upon receipt of the service. We accept VISA, MASTERCARD, DISCOVER, or AMERICAN EXPRESS for your convenience.
2. When considering payment arrangements, the following guidelines will be used:
 - a. A Patient Responsibility Agreement form must be on file.
 - b. The full balance must be arranged at the time of the first statement.
 - c. All balances must be cleared within 12 months from the date of service.
 - d. A Minimum monthly payment will be required.
 - e. A Financial Agreement may be required when circumstances require arrangements beyond our standard guidelines.
 - f. When surgery is scheduled, financial arrangements must be completed prior to the date of surgery.

C. Managed Care

Many insurance companies now have PPO and Participating Physician fee schedules. Contracts are negotiated on an annual basis. If you are part of one of these plans, please be sure to verify whether Southern Orthopedic Specialists, PA, participates with your particular plan. We also try to verify this information and alert you prior to your visit if at all possible, however, it is ultimately the patient's responsibility. If your managed care plan requires a referral from your primary care physician (PCP), you are responsible for obtaining it prior to making your appointment. If you do not have a referral by the time of your visit, you will be asked to sign a disclaimer and the charges for the visit will be your responsibility.

D. Worker's Compensation Claims

If your visit involves a worker's comp claim, notify the receptionist immediately. Authorization must be obtained prior to being seen. Please indicate if this is a new claim, open claim or if it has been some time since you spoke with your claims adjuster. Any charges not accepted as part of your claim become your responsibility.

E. Motor Vehicle Accident Claims

All motor vehicle accidents are billed to your auto insurance carrier. Once PIP is exhausted, the balance becomes your personal responsibility. We will bill your primary health insurance carrier, if applicable. Many times auto insurance will pay 80% of the charges. Patients will be responsible for the remaining 20%. Payment will be expected within our usual credit guidelines.

F. Medicare

As Medicare Participating Physicians, we accept the Medicare fee schedule. The patient is responsible for the annual deductible and 20% coinsurance at the time of service.

G. Medicare and Supplement

As Medicare Participating Physicians, we accept the Medicare fee schedule. After Medicare pays, your supplement will be filed. Only one Medicare supplement will be filed.

H. Medicaid

Southern Orthopedic Specialists, PA, is not a participating provider for Medicaid. We are not able to bill Medicaid and any patient with Medicaid insurance is considered self pay. Payment is due at time of service.

I. Disability Insurance

Disability insurance forms will be completed for a small fee. Patients are asked to complete their portion of the form and leave it with the office. The forms will be mailed directly to the insurance company with copies available, on request. Please bring the forms in early to allow for adequate processing time.

Thank you for allowing us to serve you. If you need any assistance, please do not hesitate to ask. We are here to serve you.

Southern Orthopedic Specialists, P.A.

Samuel L. Combs III, M.D. Thomas C. Mitchell, M.D. Cory R. Gaiser, D.O. Michael C. Noble, M.D.
David R. Dietrich, M.D. Rafael M.M. Williams, M.D. Steven W. Malik, M.D. James C. McLoughlin, M.D.

PLEASE PRINT

Phone: _____ (H)

Date: _____ (W)

(If none, number of nearest phone.)

Patient Name: _____
(Last Name) (First Name) (Middle Initial) (Age) (Birthdate)

Guardian (If Applicable): _____

Sex: M F Single Married Widowed Divorced Soc. Sec. No.: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip Code: _____

Name of friend or relative at different address _____ (Phone Number)

Do you currently reside in a nursing home? Yes No

If yes, name of facility: _____ Phone #: _____

Primary Insurance: _____ Employer: _____

Subscriber Name: _____ Subscriber #: _____

Subscriber DOB: _____ Subscribers SS# _____ Patient Relationship to subscriber: _____

Secondary Insurance: _____ Employer: _____

Subscriber Name: _____ Subscriber #: _____

Subscriber DOB: _____ Patient Relationship to subscriber: _____

Tertiary Insurance: _____ Employer: _____

Subscriber Name: _____ Subscriber #: _____

Subscriber DOB: _____ Subscribers SS# _____ Patient Relationship to subscriber: _____

Are you here due to an auto accident? Yes No If so, Date of Accident: _____

Are you here due to an accident at work? Yes No If so, Date of Accident: _____

Description of accident or onset of symptoms: _____

Chief Complaint: _____

Your Drugstore: _____
(Name) (Phone Number)

Name of Private Doctor or Clinic: _____

Referred By: (Above?) _____

SOUTHERN ORTHOPEDIC SPECIALISTS, PA

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures:

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves several purposes. At Southern Orthopedic Specialists, PA, these include:

Treatment:

- Basis for planning your care and treatment
- Communication among the many health professionals who contribute to your care
- A record of your medical history from which you can obtain a copy to transfer to another health professional

Payment:

- Business office can use your health information to bill you or your insurance company for services provided
- Business office can use your health information to verify you have insurance coverage and what your insurance will cover.
- Assignment of benefits will be to the health care provider, as appropriate
- A collections agency can use your health information in their efforts to obtain payment of unpaid medical bills from our office.

Health Care Operations:

- Means to educate allied health professionals
- A source of information for public health officials charged with improving the health of the nation
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve
- Business office can use your health information to audit the billing process to detect and prevent fraud and abuse

Uses and Disclosures Unique to Southern Orthopedic Specialists, PA:

- We may contact you to provide appointment reminders, insurance co-pay, and account balance reminders.
- If the practice is sold, all patient records will be transferred to the new owner(s).
- Product vendors who visit the facility may recommend their products for certain classes of individuals (for example, pharmaceutical representatives).
- We will infer that you agree to the release of your protected health information, as appropriate, to your spouse or a friend if either of them accompany you to the office for your appointment.
- We may leave telephone messages about normal labwork, excluding HIV or sexually transmitted diseases information.

Southern Orthopedic Specialists, PA, may also use and/or give out your health information for the following reasons:

- As required by the United States Department of Health and Human Services. This could be as part of an investigation or to determine if we are obeying the law.
- Protected information may be disclosed in the course of certain judicial or administrative proceedings.
- Medical information may be disclosed for law enforcement purposes or other specialized governmental functions.
- Your protected information may be disclosed as authorized by laws relating to workers' compensation or similar programs.

SOUTHERN ORTHOPEDIC SPECIALISTS, PA

Southern Orthopedic Specialists, PA, will not use or disclose your protected information for any other purpose without your written authorization. Once given, you may reverse your authorization in writing at any time.

Individual Rights

You have the following rights regarding your protected health information:

- You may request restrictions in writing on certain uses and disclosures of your protected information. Southern Orthopedic Specialists, PA, is not required to agree to your requested restriction.
- You have the right to receive communications from Southern Orthopedic Specialists, PA, in a confidential manner. You have the right to inspect and copy your medical information. This right is subject to certain specific exceptions and you may be charged a reasonable fee for any copies, mailing, and/or summarizing of your records.
- You have the right to request an amendment of your medical information. The request must be in writing and must include a reason that the amendment be included. Southern Orthopedic Specialists, PA, may deny your request for certain specific reasons. If denied, the organization will provide you with a written explanation for the denial and information regarding further rights you would have at that point.
- You have the right to receive a record of the disclosures of your medical information made by Southern Orthopedic Specialists, PA, in the six years prior to your request, except for disclosures for treatment and/or payment, and for certain other specific disclosure types.
- You have the right to request a paper copy of this Notice of Privacy Practices for Protected Health Information.

Our Duties

Southern Orthopedic Specialists, PA, is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices regarding protected health information. Southern Orthopedic Specialists, PA, is required by law to abide by the terms of this Notice, and we reserve the right to change the terms of this Notice and any revision will apply to all the protected health information we maintain. If Southern Orthopedic Specialists, PA, revises the terms of this Notice, we will post a revised notice and will make paper copies of this Notice of Privacy Practices for Protected Health Information available upon request.

Complaints

If you believe your privacy rights have been violated, you have the right to complain to Southern Orthopedic Specialists, PA, and/or to the United States Department of Health and Human Services. To complain to Southern Orthopedic Specialists, PA, please contact the organization's Privacy Officer at 850 785-3799 or by writing to Southern Orthopedic Specialists, PA, at 1827 Harrison Avenue, Panama City, FL, 32405. If you choose to file a complaint, you will not be retaliated against in any way.

Contact Information

If you would like further information regarding your rights or regarding the uses and disclosures of your protected health information, you may contact Southern Orthopedic Specialists, PA's Privacy Officer at 850 785-3799.

Effective Date

This Notice is effective as of April 14, 2003.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of Southern Orthopedic Specialists, P.A. Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Patient Printed Name

Patient or Legal Guardian Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other *(Please provide specific details)*

Employee Signature

Date

Employee Printed Name

Title

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state, law.



**SOUTHERN
ORTHOPEDIC
SPECIALISTS, P.A.**

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Spine Surgery
Orthopedic Surgery
Board Certified
(850) 785-8480

**1827 Harrison Avenue
Panama City, Florida 32405
(850) 785-4344**

Dear Patient,

Thank you for choosing Southern Orthopedic Specialists, P.A. for your medical needs. We pledge to give you the best medical care possible and treat you with friendliness, respect, and dignity. We appreciate your business.

Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. **YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

Sincerely,


Chief Financial Officer

Patient / Legal Guardian Signature: _____

Date: _____

FINANCIAL PAYMENT POLICY
Of the office of
Southern Orthopedic Specialists, P.A.

1. **REGARDING INSURANCE:** The doctor's service is provided directly to you and you are responsible for payment of services rendered. Our office participates with Medicare and many other insurance companies. Should your insurance coverage be with one or more of these companies we will, as a courtesy to you, bill your insurance along the guidelines of our contract. However co-payment, deductibles, and non-covered charges are the responsibility of the patient and payment is expected at the time services are rendered.
2. **SPECIAL ARRANGEMENTS:** There are time when making payment can be a financial hardship. It may be necessary to set up a payment plan for a patient who cannot comply with our financial policy. If you are in need of special payment arrangements, please advise our billing staff or manager as soon as possible.
3. **COLLECTION FEES:** In consideration of the services to be rendered to the patient, I individually promise, whether signing as the patient, patient's agent, or as guarantor, to pay the account of Southern Orthopedic Specialist not later than the time treatment is rendered, unless specific account payment arrangements have been previously approved by SOS. Should the account be referred to an attorney or other third party collections, the undersigned shall pay reasonable attorney fees, third party collection fees and collection expenses. I waive notice of demand as a prerequisite to the commencement of legal proceedings for medical charges. No delay or omission by the hospital shall be considered a waiver of any right. I agree that venue in any action brought against me for medical charges shall be in Bay County, Florida. The law prescribes all delinquent accounts bear interest at the highest legal rate or in the event no maximum rate, at eighteen percent (18%) per annum.

Informing our patients about our financial policy assists us in providing the best services to our patients. Thank you for taking the time to read this policy statement. Should have further questions or comments, please contact our billing staff or manager.

I hereby understand the financial policy of this office:

_____ **PATIENT NAME (Please Print)**

_____ **PATIENT or LEGAL GUARDIAN'S SIGNATURE**

_____ **DATE**

.....
MEDICARE/ALL INSURANCE AUTHORIZATION

I request that payment of authorized Medicare/Insurance benefits be made on my behalf to the provider for any services furnished me by the listed provider. I authorize any holder of medical 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. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim(s). If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claims forms of electronically submitted claims, my signature authorized release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Insurance companies.

_____ **PATIENT or LEGAL GUARDIAN'S NAME (PRINT)**

_____ **PATIENT or LEGAL GUARDIAN'S SIGNATURE**



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GENERAL PATIENT/PHYSICIAN AGREEMENT

Please read the following paragraphs, initial below each paragraph that you have read, understand and agree to the same.

In an effort to provide the most efficient and effective healthcare, your treating physician will diagnose your illness according to your complaints. Appropriately, the patient understands and authorizes treating physician and/or staff to communicate with previous physicians by any method, to include a "physician only" web site and/or any physician that can assist with the care of the patient as long as confidentiality is kept at the professional level. I have read, understand, and agree with the above.

Patient/Legal Guardian Initials: _____

The patient understands that he or she is not required to use treating physician or any other physician employed by or under the direction of this facility or practice for general healthcare and/or surgery. The patient understands medicine is not an exact science and there is risk involved in any medical procedure. The patient understands he or she is being treated at his or her own risk. It is further understood that in the event of any controversy or dispute which might arise between the patient and the physician, regardless of whether the dispute concerns the medical care rendered by the treating physician or any manner whatsoever, then the patient agrees that the controversy or dispute shall be resolved by arbitration as provided by the Florida Arbitration code, Chapter 682 & 684, Florida Statutes. This arbitration shall be binding and shall be in lieu of and instead of any trials by judge or jury. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. Each party shall be entitled to the discovery provided for under rules 1.280-1.390, Florida Rules of Civil Procedure. The panel of arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and may be enforced by a court of competent jurisdiction. I have read, understand and agree with the above.

Patient/Legal Guardian Initials: _____

"Physician Orders" are meant to improve and/or resolve the patient's medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician's care and/or facility thus releasing the treating physician and/or facility from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can include but is not limited to missing, postponing or refusal of additional tests to rule out, confirm or discover illnesses and misusing medications. I have read, understand and agree with the above.

Patient/Legal Guardian Initials: _____

I _____, as the patient/guardian, have read and understand all paragraphs above by initialing below each paragraph. I have agreed to abide by their content by signing below.

In witness whereof, I have set my hand this date ____ / ____ / ____.

Print Patient's Name

Physician or Authorized Agent

Patient or Legal Guardian Signature

SO

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Board Certified
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1827 Harrison Avenue
Panama City, FL 32405
(850) 785-4344

PERMISSION TO RELEASE MEDICAL INFORMATION

Patient Name: _____

I give permission for the following:

_____ Relationship _____

_____ Relationship _____

to speak with my Doctor/Doctors at Southern Orthopedic
Specialists, P.A. concerning my medical condition.

I understand that I have the right to revoke this authorization at any
time. I understand that if I revoke this authorization I must do so in
writing. I understand that this authorization expires two years from
date signed.

Signature

Date

MEDICAL HISTORY

NAME _____ AGE _____ DATE _____
 DATE FORM FILLED OUT _____ HEIGHT _____ WEIGHT _____

NOTE: Please fill out and bring to your first appointment. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

1. SURGERY

List operations you have had:

TYPE	DATE	HOSPITAL	SURGEON	COMPLICATIONS

2. ILLNESSES

DIAGNOSIS	DATE	HOSPITAL	DOCTOR

2. ACCIDENTS AND INJURIES

TYPE	DATE	HOSPITAL	DOCTOR

4. MEDICATIONS

NAME	STRENGTH	DOSAGE	PRESCRIBING DR.

5. ALLERGIES - Please circle any medications to which you are allergic:

- Penicillin Sulfa Codeine Morphine Demerol Aspirin
 Tetanus Horse Serum Latex allergy Tape Iodine

Please list any substance to which you are allergic, not covered above.

6. FAMILY HISTORY - Has any immediate blood relative ever had: CHECK IF YES

- Cancer Heart Disease Mental Illness Congenital Deformities
 Diabetes Stroke
 Other _____

7. SOCIAL HISTORY - Present occupation _____ Number of children _____

- Married I live alone
 Single I live with someone who can care for me
 Widowed I live with someone who is unable to care for me
 Divorced I live alone but have friends/family who can care for me

8. HABITS

Smoking:

- I do not smoke and have never smoked
 I do not smoke now, but use to smoke
 packs per day _____ How many years _____ Date you quit _____
 I presently smoke
 Packs per day _____ How many years _____

Alcohol:

- Do you consume alcoholic beverages now? YES NO
 Do you have a "drinking" problem now? YES NO
 Have you ever had a "drinking" problem? YES NO

Drugs: Do you use recreational drugs now? YES NO (Marijuana, Cocaine, LSD, Crack)
 Have you ever used recreational drugs? YES NO
 Do you use sleeping pills, tranquilizers,
 or pain meds on a regular basis? YES NO

9. REVIEW OF SYSTEMS - Answer YES if you currently have or have ever had the following:

Problem	Yes	No	Problem	Yes	No
Glaucoma			Stomach Ulcers		
Poor Eyesight			Jaundice		
Poor Hearing			Hiatal Hernia		
Nosebleeds			Reflux		
Hoarseness			Intestinal Bleeding		
Difficulty Swallowing			Hernia		
Neck Pain			Diverticulitis		
Frequent Headaches			Hemorrhoids		
Thyroid Disease			Bloody Stools		
Pneumonia			Hepatitis		
Pleurisy			Indigestion		
Bronchitis			Gallbladder Problems		
Asthma			Colitis		
Hay Fever			Appendicitis		
Shortness of Breath			Gastritis		
Chest Pain			Bladder Control Problems		
Pulmonary Embolus			Kidney Stones		
Persistent Cough			Kidney/Bladder Infections		
Heart Attack			Prostate Problems		
High Blood Pressure			Frequent Infections		
Heart Valve Disease			Cancer		
Irregular Heartbeat			Unexplained Weight Loss		
Heart Failure			Diabetes		
Heart Murmur			Chronic Back Pain		
Circulatory Problems			Sciatica		
Varicose Veins			Polio		
Phlebitis			HIV Positive		
Anemia			AIDS		
Blood Clot in Legs			Psoriasis		
Epilepsy			Skin Problems		
Dizziness			Gout		
Stroke			Osteoarthritis		
Nervous Breakdown			Rheumatoid Arthritis		
Mental Illness			Rheumatic Fever		
Insomnia			Other:		
Concussion					
Meningitis					
Depression					