WELCOME TO SEVEN SPRINGS ORTHOPAEDICS & SPORTS MEDICINE

For office use only: *Account #* *Provider:* *Date:*

PATIENT INFORMATION

Full Name: *(First)* *(Middle)* *(Last)*
Home Address:
City: State: Zip Code:
Home Phone ( ) - SS # - - ❑M ❑F Birth Date: / / Age:
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed Spouse's Name:
Patient's Employer: Work Phone: ( ) -
Employer's Address:
Occupation: E-mail Address: Cell Phone: ( ) -

RESPONSIBLE PARTY *(BILL TO)* INFORMATION

--- Complete this section ***ONLY*** if someone ***other*** than the patient is financially responsible. ---

Responsible Party: *(First)* *(Middle)* *(Last)* ❑ M ❑ F
Address:
City: State: Zip Code:
Home Phone: ( ) - Work Phone: ( ) - Cell Phone: ( ) -
Social Security #: - - Relationship to Patient: Birth Date: / /
Name of Employer:

EMERGENCY CONTACT INFORMATION

Name: Relationship:
Home Phone: ( ) - Work Phone: ( ) - Cell Phone: ( ) -

REFERRAL INFORMATION

Who referred you to our office? Who is your Family Physician?

INSURANCE INFORMATION

Primary Insurance Co: Group #: Policy #:
Name of Insured: SS # - - Birth Date / / Relationship to Patient:

Secondary Insurance Co: Group #: Policy #:
Name of Insured: SS # - - Birth Date / / Relationship to Patient:

If you have an HMO insurance plan, did you contact your Primary Care Physician (PCP) for a referral? ❑**Yes** ❑**No**

Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts for the date of service you are seen. By signing this form, I agree to be responsible for any legal fees and/or fees incurred in the collection of charges for this account. I authorize the release of any medical information necessary to process my claim(s). I authorize payment(s) of medical and surgical benefits to Seven Springs Orthopaedics & Sports Medicine.

______________________________ Signature of Patient or Responsible Party

______________________________ Today's Date

MEDICAL HISTORY

SEVEN SPRINGS ORTHOPAEDICS & SPORTS MEDICINE

Today's Date:__________

PATIENT INFORMATION

Name:__________

Date of Birth:__________ **Age:** __________

Height:__________ **Weight:**__________

Referring Physician:__________

What are you being seen for today? *(include right or left body Part)*__________

Injury Date:__________

Work Related: ☐YES ☐NO

Reported to Employer: ☐YES ☐NO

Attorney Name: __________

SYMPTOMS

Describe your symptoms: __________

Symptoms Are: ☐MILD ☐MODERATE ☐SEVERE

Symptoms Are: ☐CONSTANT or ☐INTERMITTENT

Your other symptoms associated to this injury are:

☐None ☐Fever ☐Chills ☐Weight Loss ☐Tingling ☐Numbness ☐Swelling ☐Locking ☐Giving Way

When did these symptoms begin? __________

What occurred for these symptoms to begin?

What makes you feel better?__________

What makes you feel worse?__________

Check all test you have had in the last (4) months in regards to your current injury:

☐X-Rays ☐MRI ☐CT Scan ☐EMG ☐Bone Density ☐Bone Scan ☐Blood Work

Facility/Hospital:__________Date:______

MEDICAL HISTORY/REVIEW OF SYSTEMS

Check all the health problems You have had:

☐Diabetes ☐Heart Disease ☐High Blood Pressure
☐stroke ☐Lung Disorder ☐Sleep Apnea
☐Hepatitis ☐Depression ☐Neurological Disorder
☐HIV ☐Asthma ☐Weight Gain/Loss
☐Cancer ☐Anemia ☐Bleeding Problems
☐Chest Pains ☐High Cholesterol ☐Shortness of Breath
☐Headache ☐Bladder problems ☐Bowel Problems
☐Other:__________

Check all surgeries You have had:

☐Joint Surgery ☐Spine Surgery ☐Heart Disease
☐Hysterectomy ☐C-Section ☐Tonsillectomy
☐Appendectomy ☐Gallbladder
☐Other: __________

FAMILY HISTORY

Check all health problems blood members of your family have had and list that relative:

☐Arthritis __________ ☐Osteoporosis__________
☐Cancer__________ ☐Diabetes__________
☐Scoliosis __________ ☐Heart Disease__________
☐Stroke__________ ☐Bleeding Disorder__________
☐Blood Clots __________ ☐Hypertension__________
☐Other:__________

SOCIAL HISTORY

Do you smoke? ■YES ■NO

Number of packs per Day:__________

Do you drink alcohol? ☐YES ☐NO

Number of drinks per day:__________

Have you been treated for, or do you currently have a problem with alcohol, illegal drug use, or prescription drug abuse? ☐YES ☐NO

MEDICATIONS

List the name, dosage, and frequency of all medications you are currently taking:

Medicine	Dosage	Frequency

ALLERGIES

List the name of any drugs you are allergic to and what it does to you when taken:

☐LATEX ALLERGY

Internal Use Only:

Physician's Review__________Date________

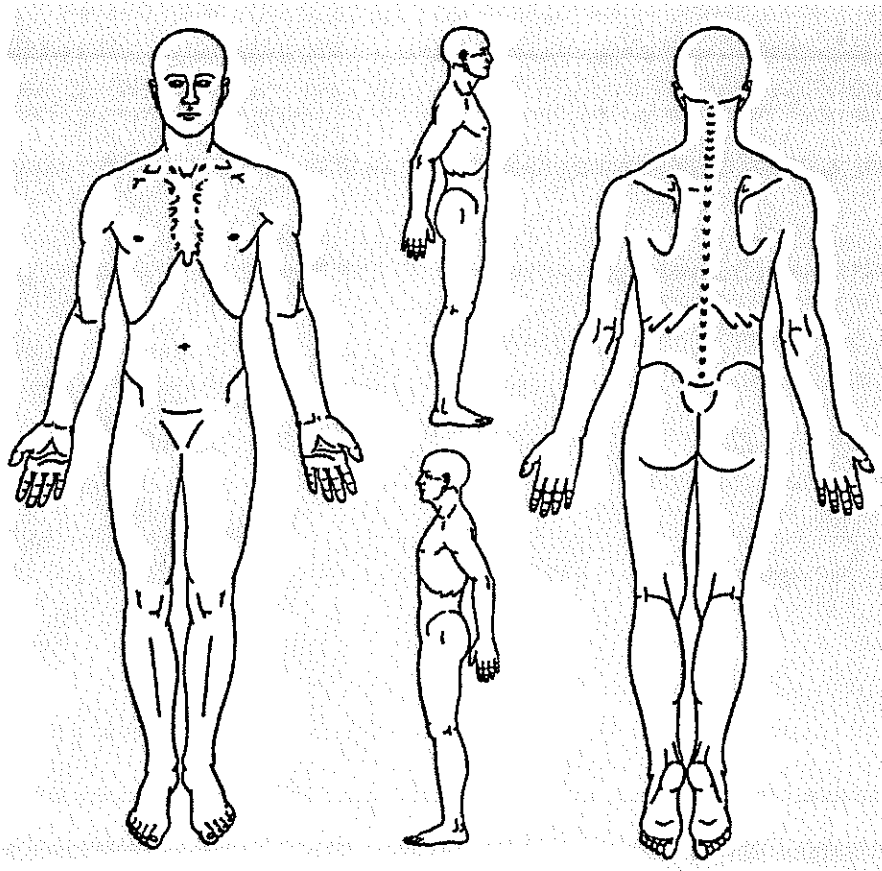
SEVEN SPRINGS ORTHOPAEDICS
& SPORTS MEDICINE

PAIN DRAWING

PATIENT NAME: (please print)____ Today's Date: ______________

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

A = Aching	**B = Burning**	**R = Radiating Pain**	**D = Dull Pain**
N = Numbness	**S = Stabbing**	**P = Pins & Needles**	**O = Other**



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

Notes: (Office Use Only)

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SEVEN SPRINGS
ORTHOPAEDICS
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DME WAIVER

Patient's Name: ________________________ **Account Number:** ________________

Seven Springs Orthopaedics & Sports Medicine has determined that a brace, splint or some other durable medical equipment (DME) would be best to protect my injury while it heals.

I authorize Seven Springs Orthopaedics & Sports Medicine to submit a claim to insurers as may be required and to receive payment directly.

I understand that I am responsible for deductibles and co-payments not covered by my insurance. Should my insurance plan not cover all or part of the charges, I understand that I will be responsible for payment, not to exceed the insurance allowable cost.

Description of Item: ____

____

____

Patient/Authorized Signature: ______________________ Date: ______________

Diagnosis: (Right) ______________________ (Left) ______________________

Provider's Signature: ____

Label(s): ____

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SEVEN SPRINGS

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Spring Hill, TN 37174
615-861-4444 (p)
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EFFECTIVE WEDNESDAY, 8-29-12

ALL PATIENTS

CANCELLATION/NO SHOW POLICY

We understand there may be times when you miss an appointment due to emergencies or obligation to work or family. However, you MUST call the office at 615-861-4444 at least 24 hours prior to your scheduled appointment to cancel or reschedule your appointment.

Our new policy for missing an appointment without cancelling in advance will be a $20.00 no-show fee and you will not be allowed to schedule another appointment until that fee is paid in full.

Also, if you no-show or cancel an appointment, NO medications will be refilled.

____
Patient's initials

______________________________ ________________
(Print Name) ***(Date)***

______________________________ ________________
(Witness) *(Date)*

SEVEN SPRINGS ORTHOPAEDICS & SPORTS MEDICINE

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have received a copy of the Notice of Privacy Practices of Seven Springs Orthopaedics & Sports Medicine.

Date Received: ______________________________

Full Name: *(Please print)* ______________________________

Signature: ______________________________

Date of Birth: ______________________________

Date Signed: ______________________________