Chart No. _____

Acct. No. _____

Dr. _____
(For Office use only)

CAMDEN BONE & JOINT, LLC

PATIENT HISTORY (Please Print)

Date _____

☐ MARRIED
☐ SINGLE
☐ WIDOWED
☐ DIVORCED
☐ SEPARATED

Last Name _____ First _____ MI ____

Address _____

Phone # ( ) _____ Date of Birth _____ Age _____ Sex _____

Social Security No. _____ Weight _____ Height _____

IN THE EVENT OF SURGERY OR FRACTURE TREATMENT, THE PATIENT IS RESPONSIBLE FOR BRINGING IN COMPLETED & SIGNED INSURANCE FORM

Person responsible for paying this bill ☐ Father ☐ Mother ☐ Spouse ☐ Other _____

Primary Insurance _____ ID/Policy No. _____ Group No. _____

Name of Insured _____ Home Address _____

Secondary Insurance _____ ID/Policy No. _____ Group No. _____

Name of Insured _____ Home Address _____

Primary Insured's DOB _____ SSN _____ Employer _____

Secondary Insured's DOB _____ SSN _____ Employer _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION BY CAMDEN BONE & JOINT, LLC, AS NECESSARY TO PROCESS ANY INSURANCE CLAIM AND REQUEST PAYMENT OF BENEFITS TO CAMDEN BONE & JOINT, LLC FOR SURGERY, FRACTURE FEE OR ANY UNPAID BILLS.

Signature _____ Relationship to Patient _____ Date _____

Father's Information

Name _____ Employer _____

Address _____ Address _____

City _____ State _____ City _____ State _____

Zip _____ Phone # ( ) _____ Zip _____ Phone # ( ) _____

DOB _____ SSN _____

Mother's Information

Name _____ Employer _____

Address _____ Address _____

City _____ State _____ City _____ State _____

Zip _____ Phone # ( ) _____ Zip _____ Phone # ( ) _____

DOB _____ SSN _____

Nearest Relative other than above: Name _____ Address _____
(with Telephone)
City _____ State _____ Zip _____ Phone # ( ) _____

Has patient ever been treated by any Camden Bone & Joint physician before? _____ If "yes" when _____

Give full name of referring physician _____ Address _____ Phone # ( ) _____

Is patient **allergic** to any medications that you know of _____ If "yes" give name _____

Has patient been seen or treated for present problem _____ If "yes" Where _____

Has patient had X-Rays taken for this problem _____ If "yes" Where _____ Did you bring films? _____

★ Specific part of the body that is causing problem _____ Injured @ work? _____

Date of Accident or onset of problem _____ If injury, or accident how did it happen?

_____

Where _____

Name:
DOB:
Chart:
Age:
Date:

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PATIENT MEDICAL HISTORY

Patient Name: _____

Chart Number: _____

Describe the pain — *Check all that apply*

❑ Sharp ❑ Dull ❑ Burning ❑ Other _____ _____

❑ Intermittent ❑ Constant ❑ One area

❑ Multiple areas ❑ Other _____

How severe is the pain on a scale of 1 to 10 with 10 being the worst pain imaginable?

Circle one 0 1 2 3 4 5 6 7 8 9 10

What makes the problem worse? _____

What makes the problem better? _____

Does the problem/pain occur at any particular time of the day? ❑ Yes ❑ No ❑ Not sure

If so when does it occur? (check all that apply) ❑ Morning ❑ During day ❑ After work ❑ At night ❑ All the time ❑ Other

REVIEW OF SYSTEMS

Do you presently have any of the following problems

❑ Headaches ❑ Watery Eyes ❑ Blurry Vision ❑ Double Vision ❑ Cough ❑ Wheezing ❑ Shortness of Breath

❑ Chest Pain ❑ Indigestion ❑ Joint Pain ❑ Anxiety ❑ Burning with urination ❑ Incontinence

❑ Numbness ❑ Weakness ❑ Fainting Spells ❑ Diarrhea ❑ Rashes ❑ Leg Swelling

❑ Seizures ❑ Constipation ❑ Skin Ulcers ❑ Problems Sleeping ❑ Depression ❑ Joint Swelling

MEDICAL ILLNESSES

Do you have presently or have you ever been diagnosed with any of these illnesses?

❑ High Blood Pressure ❑ Heart Disease ❑ Arthritis ❑ Stroke

❑ Liver Disease ❑ Asthma ❑ Diabetes ❑ Kidney Disease

❑ Stomach Ulcers ❑ Blood Clots in Legs ❑ Cancer ❑ Depression

❑ Others _____ _____ _____

SURGICAL HISTORY

Have you ever had any of the following surgeries?

❑ Heart Bypass ❑ Appendectomy ❑ Gall Bladder Removal

❑ Hysterectomy ❑ Tonsillectomy ❑ Fracture Surgery

❑ Arthroscopy ❑ Joint Replacement ❑ Spine Surgery

❑ Others _____ _____

FAMILY HISTORY

Do any of the following medical problems run in your family?

❑ Cancer ❑ Heart Disease ❑ Arthritis

❑ Diabetes ❑ High Blood Pressure ❑ Depression

❑ Bleeding Problems ❑ Osteoporosis

❑ Others _____ _____

MEDICATIONS ❑ LIST ATTACHED

Please list any medications that you take, including how much and how often if possible. Include over the counter medications and any supplements (glucosamine, ginkgo biloba, etc) You may attach a list if you have one!

ALLERGIES

Are you allergic to any medications?

❑ Penicillin ❑ Codeine

❑ Aspirin ❑ Novocain

❑ Others _____ _____

Name:
DOB:
Chart:
Age:
Date:

Acct #: _____ Name: _____

ePrescribing

Camden Bone & Joint is in the process of implementing ePrescribing.

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your preferred pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.

The benefit to you:

- Less confusion caused by handwritten prescriptions and unclear phone calls
- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to the pharmacy
- A safer, faster, easier way to get your prescription filled

Patient Preferred Pharmacy
Complete Pharmacy information below to indicate which pharmacy your electronic prescriptions will be sent.

_____
Preferred Pharmacy Name / Phone Number

_____
Preferred Pharmacy Address / Street, City, State, Zip

Patient Consent

I agree that Camden Bone & Joint may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____
Patient Signature Date

Patient Decline

I decline that Camden Bone & Joint may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. This does not prevent Camden Bone & Joint from ePrescribing.

_____ _____
Patient Signature Date

Name:
DOB:
Chart:
Age:
Date:

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. I understand that this information may be disclosed for treatment, payment or health care operations.

Acknowledgement of Receipt of Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices that gives a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Patient's Name | Chart Number | Account

Signature of Patient or Legal Representative | Witness

Date | Notice Eff. Date

Request the following restrictions to the user of disclosure of my health information

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