Name:
DOB:
Chart:
Age:
Date:

Chart No. _____
Acct. No. _____
Dr. _____
(For Office use only)

CAMDEN BONE & JOINT, LLC

PATIENT HISTORY (Please Print) Date _____

Last Name _____ First _____ MI ____

Address _____ Apt. No. _____

City _____ State _____ Zip _____

Sex _____ Home Phone No. _____ Work No. _____

- ❑ MARRIED
- ❑ SINGLE
- ❑ WIDOWED
- ❑ DIVORCED
- ❑ SEPARATED

Social Security No _____ Age _____ Date of Birth _____ Weight _____ Height _____

DEMOGRAPHICS			SMOKING STATUS
Race	**Ethnicity**	**Language**	☐ Current every day smoker
☐ American Indian	☐ Hispanic Origin	☐ Chinese	☐ Current some day smoker
☐ Asian	☐ Non-Hispanic	☐ English	☐ Smoker, current status unknown
☐ Black	☐ Type-Unknown	☐ French	☐ Never smoker
☐ Native Hawaiian		☐ Hebrew	☐ Former smoker
☐ Type-Unknown		☐ Hindi	☐ Unknown if ever smoked
☐ White		☐ Japanese	
		☐ Portuguese	
		☐ Russian	
		☐ Spanish	
		☐ Yiddish	

Email Address: _____ ____ I do not have email address
(For Office use only) Date Received _____ Date Sent to Insurance _____ Initials _____

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

Person responsible for paying this bill ❑ Self ❑ Other _____

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

Name of Insured _____ Insurance Address _____

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

Name of Insured _____ Insurance Address _____

If Covered under Spouse's Insurance - Please give Spouse's DOB _____ SSN _____

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 _____

Patient's Occupation _____

Patient's Employer _____ Employer Phone # _____

Employer Address _____ Injured @ Work? _____

Spouse's Name _____ Employer Phone # _____

Spouse's Employer & Address _____

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

Name:
DOB:
Chart:
Age:
Date:

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

Given full name of referring physician _____ Address _____

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" when _____

Where (or by whom) _____

Has patient had X-Rays taken for this problem _____ If "yes" when _____

Where _____ Do you have them with you _____

* Specific part of the body that is causing problem _____

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

_____

Where _____

Test Results

We will not contact you if your test results were within normal range. We will contact you if there is a problem. After scheduling a test you usually will be scheduled for a follow-up appointment so the doctor can explain the results and give you any other choices of treatment.

Prescription Policy

Please bring all medications (even those received from another Physician) with you, or a current list of meds and directions.

All medication requests must be requested during office hours so that the physician has access to your medical record. Under no circumstances will they call in medications after 5:00 p.m. The nurse will call in your medications on the same day you requested. Please check with your pharmacy to see if it has been called in.

_____ _____

Printed Name of Patient or Responsible Party 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

BC2

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:

* 5 5 5 5 5 5 5 5 5 5 - 2 8 *

PATIENT MEDICAL HISTORY

Patient Name: _____

Chart Number: _____

Describe the pain *Check all that apply*
❑ Sharp ❑ Other _____
❑ Dull _____
❑ Burning _____
❑ Intermittent ❑ Multiple areas
❑ Constant ❑ Other
❑ One area _____

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 ❑ Chest Pain ❑ Numbness ❑ Seizures
❑ Watery Eyes ❑ Indigestion ❑ Weakness ❑ Constipation
❑ Blurry Vision ❑ Joint Pain ❑ Fainting Spells ❑ Skin Ulcers
❑ Double Vision ❑ Anxiety ❑ Diarrhea ❑ Problems Sleeping
❑ Cough ❑ Burning with urination ❑ Rashes ❑ Depression
❑ Wheezing ❑ Incontinence ❑ Leg Swelling ❑ Joint Swelling
❑ Shortness of Breath

MEDICAL ILLNESSES

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

❑ High Blood Pressure ❑ Liver Disease ❑ Stomach Ulcers ❑ Others
❑ Heart Disease ❑ Asthma ❑ Blood Clots in Legs _____
❑ Arthritis ❑ Diabetes ❑ Cancer _____
❑ Stroke ❑ Kidney Disease ❑ Depression _____

SURGICAL HISTORY

Have you ever had any of the following surgeries?

❑ Heart Bypass ❑ Hysterectomy ❑ Arthroscopy ❑ Others
❑ Appendectomy ❑ Tonsillectomy ❑ Joint Replacement _____
❑ Gall Bladder Removal ❑ Fracture Surgery ❑ Spine Surgery _____

FAMILY HISTORY

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

❑ Cancer ❑ Diabetes ❑ Bleeding Problems ❑ Others
❑ Heart Disease ❑ High Blood Pressure ❑ Osteoporosis _____
❑ Arthritis ❑ Depression _____

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 ❑ Aspirin ❑ Others _____
❑ Codeine ❑ Novocain _____