SUMMIT
ORTHOPEDICS, SPINE & SPORTS MEDICINE

Patient Information and Profile

Name: _____ Date: _____ / _____ / _____

Are you . . . ☐ Married: ☐ Single: ☐ Divorced: ☐ Widow(er): Number of Children: _____

Reason for Today's Visit: _____

Accident: ☐ Yes ☐ No Date of Accident or Onset of Symptoms: / /

How Did This Occur: _____

Was this an auto accident? ☐ Yes ☐ No Is this related to work injury? ☐ Yes ☐ No

List all of your current medical conditions (for example: High Blood Pressure, Asthma, Diabetes):

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have hepatitis or any other chronic communicable disease? _____

(Females) Are you pregnant? ☐ Yes ☐ No Date of your last menstrual period: _____

Have you had a recent flu vaccine? ☐ Yes ☐ No Have you had a pneumonia vaccine? ☐ Yes ☐ No

Medications you are currently taking (dose & schedule):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are you currently taking any blood-thinners (Coumadin, Aspirin, NSAID's, etc.)? _____

Do you experience complications with anesthesia? _____

DRUG ALLERGIES: _____

Are you allergic to Betadine? ☐ Yes ☐ No Adhesive Tape? ☐ Yes ☐ No Xylocaine? ☐ Yes ☐ No

Please list any surgeries you have had, as well as the approximate dates of the procedure:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

List all medical illnesses affecting your immediate family, and your relation to that person:

1. _____ Relation: _____ 3. _____ Relation: _____
2. _____ Relation: _____ 4. _____ Relation: _____

Do you currently use tobacco products? ☐ No ☐ Yes (If yes, how much): _____

Do you currently consume alcohol? ☐ No ☐ Yes (If yes, how often): _____

Please Complete Both Sides of this Sheet!

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Patient Information and Profile
General Medical History

Please check ✓ YES or NO for the following: (If you do not check anything, we will assume your answer is NO)

CONSTITUTIONAL
Weight Loss ☐ Yes ☐ No
Fever ☐ Yes ☐ No

EYES
Discharge From Eye ☐ Yes ☐ No
Impaired Vision ☐ Yes ☐ No

HENT
Headaches ☐ Yes ☐ No
Neck Stiffness ☐ Yes ☐ No

CARDIOVASCULAR
Chest Pain ☐ Yes ☐ No
Lightheadedness ☐ Yes ☐ No

RESPIRATORY
Shortness of Breath ☐ Yes ☐ No
Wheezing ☐ Yes ☐ No

GASTROINTESTINAL
Nausea ☐ Yes ☐ No
Constipation ☐ Yes ☐ No

GENITOURINARY
Possible Pregnancy ☐ Yes ☐ No
Frequency ☐ Yes ☐ No
Incontinence ☐ Yes ☐ No

INTEGUMENT
Rash ☐ Yes ☐ No
New Skin Lesions ☐ Yes ☐ No

NEUROLOGIC
Muscular Weakness ☐ Yes ☐ No
Seizures ☐ Yes ☐ No

MUSCULOSKELETAL
Joint Pain ☐ Yes ☐ No
Muscle Cramps ☐ Yes ☐ No

Any other significant medical history or additional comments: _____

_____

_____

_____

_____

_____

_____

Name of person filling out this form (if different than patient): _____

Relation to patient: _____

Patient Signature: _____

Please Complete Both Sides of this Sheet!

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PATIENT INFORMATION

Patient Name: Last_____ First_____ Middle_____
Address: _____City_____ State_____ Zip Code_____
Home: _____ Work: _____ Cell: _____
Email: _____ Marital Status: _____ Birthdate: _____/_____/_____
Social Security #: _____ Sex: _____ Race: _____
Employer: _____ Employer Ph#: _____
Spouse's Name (if married): _____ Spouse's Employer: _____
Emergency Contact: _____ Phone: _____
Relatives/friends who are patients here? _____ Who referred you to us: _____
Pharmacy Name: _____ Pharmacy Phone #: _____
Primary Care Provider: _____Referring Provider: _____
Other Specialists Seen: _____

INSURANCE INFORMATION

Insurance Company (Primary): _____
Policy Holder's Name: _____ Birthdate _____/_____/_____
Contract Number: _____ Group Number: _____
Insurance Company (Secondary): _____
Policy Holder's Name: _____ Birthdate _____/_____/_____
Contract Number: _____ Group Number: _____

CONSENT FOR TREATMENT

I consent to necessary treatment, including drugs, medication, performance and operation of X-ray, or other studies that may be used by the attending physician, nurse, or staff.

CONSENT FOR E-PRESCRIBING

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

NON-COVERED SERVICE AGREEMENT

As your physician, I want to provide you with the best care possible. There may be certain routine services performed during your visit(s), such as dexa scans, pap smears, biopsies, ultrasounds/X-rays, lab work, injections, and/or other testing that I feel necessary for the maintenance of your good health that may not be covered by your insurance contract. By signing below, you agree that you will be responsible for costs not covered by your insurance.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of the Notice of Privacy Practices.

SIGNATURE: _____ **DATE**:_____

Cancellation Policy/No Show Policy

We strive to promote the best quality healthcare for our patients. One of the ways we meet your healthcare needs is to provide appointments with our physicians in a timely manner, many times within the same day. In order to provide these appointments, we have the following No Show/Cancellation policy.

1. *Cancellation/ No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an Appointment, you may be preventing another patient from receiving much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

If an appointment is not cancelled at least 24 hours in advance you may be subject to fees which are not covered by your insurance company. More than 3 no shows within a six month period will result in dismissal from the practice. Violators will receive a letter after the second no show as a reminder of the policy.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and our physicians on time.
If a patient is 15 minutes past their scheduled time, it may be necessary to reschedule your appointment.

3.*Cancellation/ No Show Policy for Surgery/Procedure*

Due to the large block of time needed for surgery and/or procedures, last minute cancellations can cause
problems and added expenses for the office.

If your are scheduled for a surgery/procedure is not cancelled at least 10 days in advance you may be subject to fees which are not covered by your insurance company.

4. Account balances

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.
Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.
Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____ _____ ____/____/____

Print Name Patient Signature Patient/Guardian Date

NARCOTIC NOTICE TO PATIENTS

Grandview Medical Group will NOT provide prescriptions for hypnotic sedatives, stimulants and other controlled drugs to new patients, unless it is deemed necessary by the physician for situations that include severe illness or injury that has occurred within 24-48 hours for the date of the office visit. New patients are given this notice at the time of the appointment and patients should understand that if long term pain management is needed as part of their total medical care, an appointment with a chronic pain management facility is recommended and should be scheduled by the patient. Records from the treating physician will be requested as we may not be able to accept any records brought in by the patient. New patients should be aware that all patients, new and established, are subject to query at the State of Alabama Department of Public Health Prescription Drug Monitoring Website for verification of narcotic/analgesic use and/or random drug screening.

If a new patient should request a narcotic/analgesic prescription for a chronic/long term condition after they have read, understood and agreed by signature to this policy, the request will be denied and possible dismissal of medical services will be enacted at the physician's discretion. Also, if at any time, Grandview receives a report that a patient, new or established, is receiving inappropriate or duplicate prescriptions of narcotics/analgesics from other physicians, the patient will be immediately dismissed from receiving medical services from Grandview Medical Group indefinitely.

l have read and understood the Narcotics Policy for Grandview Medical Group and agree to follow this policy as a patient of Grandview Medical Group.

Signature:_____ **Date:** _____

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AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

_____ **I DO NOT** wish to have test results or other medical information released to any person other than myself.

_____ **I DO** wish to have test results or other medical information released to the following person(s):

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

It is the responsibility of the patient to notify this office of any changes in the above information. If changes do occur, the patient must file another Authorization for Release of Patient Information with this clinic. Please understand that it may be necessary for us to disclose some or all of the Information contained in your medical records to other physicians, nurses, and/or healthcare providers (collectively referred to as "providers"). At times, other providers assist using assessing a patient's condition, screening for potential problems, or providing consultation under certain circumstances. All healthcare providers are required by law to maintain your patient confidentiality.

Also, due to the increased awareness of quality care and outcome measurements, it may be necessary to disclose information regarding your care to healthcare agencies (both private and governmental), your insurance company and/or your self-insured employer. Regarding the information going to your employer, other than information needed to verify your insurance coverage, the data released will consist of statistical information only.

_____ _____

Patient Signature Date

_____ _____

Printed Name SS#