Mooresville PPM, LLC

Outpatient Information

PATIENT INFORMATION	Account #:		Medical Record#:	Date:	
Patient Name:			Referring Doctor:		
Billing Address:			City	State	Zip
Physical Address:			City	State	Zip
(H) Phone:	(C) Phone:		Work Phone:	Other:	
Primary Doctor			Employer/School:		
Social Security #:	Date of Birth:	Age	Martial Status:	Sex:	
Emergency Contact:	Relationship:		(H) Phone:	(C) Phone:	
Responsible Party:	Relationship:		DOB:	SS#:	
Email (responsible party if minor/child)					
Responsible Party Address:					
City:	State	Zip	(H) Phone:	(C) Phone:	
INSURANCE INFORMATION					
Primary Insurance:	Employer:		Secondary Insurance:	Employer:	
Insurance ID #:	Insurance Group #:		Insurance ID #:	Insurance Group #:	
Insured Name:			Insured Name:		
Address:			Address:		
City	State	Zip	City	State	Zip
DOB:	Insured Social Security #:		Insured DOB:	Insured Social Security #:	

Financial Responsibility and Assignment of Insurance Benefits:
I guarantee payment to Mooresville PPM, LLC and its affiliates (Mooresville PPM, LLC) of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be payable to me, to Mooresville PPM, LLC for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

Signature of Patient or Authorized Person: ______________________ ***Date/Time:*** ____________

Insured Party or Financial Guarantor (if different from above): ______________________ ***Date/Time:*** ____________

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

❑ Interpreter Accepted ______________________________ ❑ Interpreter Refused

(Name/Number of Person/Services Chosen/Used

NEW PATIENT / PROBLEM SHEET

Appointment Date: __________ Provider__________________________

BP_____/_______ Pulse________
Temp_____ Hgt._____ Wgt._______

Patient Name (Please Print) ____

Age_____ F___M___ Dominant Hand: R__ L__ Height____/Weight_____ Did you bring Xrays? Y__ N__

Who requested that you visit this office? (Name)________________ __MD __PA __Attorney __Self

What is the main reason for this visit? __Pain __Numbness __Weakness __Swelling __Stiffness __Other

What Body part is involved? Please mark in the table below. If you have MORE THAN ONE, see receptionist.

Neck____	and radiates __R Arm __L Arm __Neither	Shoulder __L __R	Elbow __L __R	Hand __L __R	Pelvis __L __R	Knee __L __R	Foot __L __R
Back____	and radiates __R Arm __L Arm __Neither	Arm __L __R	Wrist __L __R	Finger T2 3 4 5 __L __R	Hip __L __R	Ankle __L __R	Toe __L __R

How long ago did it start? ___Days, ___Weeks, ___Months, ___Years. Have you has a problem like this before?___

In this section, check ONE BOX which best describes how your problem started. Then answer the questions below

Answer or Comments:

__NO INJURY (Onset was __Gradual OR __ Sudden) ______________________________

__INJURY (__Accident __ Sport NOT Auto/work) ______________________________

Date: ________________ ______________________________

Where and how did it happen? ______________________________

What Sport? ____________ ______________________________

School __________________ ______________________________

__INJURY AT WORK Date__________ ______________________________

__WORK RELATED- (BUT NOT INJURY) ______________________________

Date: __________________ ______________________________

How did your job cause this problem? ______________________________

__AUTO ACCIDENT Date: __________ ______________________________

How was your care hit?

On the scale of 0-10 (10 is the worst) how severe is you pain (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? ___Sharp ___Dull ___Stabbing ___Throbbing ___Aching ___Burning________________

The pain is ___constant ____Come and goes (intermittent) ____ Does your pain wake you from sleep __Yes __No

Do you have ___Swelling ____Bruise ____ Numbness ____Tingling ____Weakness ____Loss of control of bowel or bladder

Since my problem started, it is: ___Getting better ___Getting worse ___Unchanged

What makes your symptoms worse? ___Standing ___Walking ___Lifting ___Exercise ___Twisting ___Lying in bed ___Bending ___Squatting ___Kneeling ___Stairs ___Sitting ___Coughing ___Sneezing

What makes your symptoms better? ___Rest ___Heat ___Ice ___Elevation ___Other______________________________

Which medications have you been taking NOW (or previously) for this problem? ______________________________

Have you had any of these treatments? Injection ___Yes ___No, Brace ___Yes ___No, Physical Therapy ___Yes ___No

Were you seen in the ER for this problem? __Yes __No Which ER? ______________________ Date: ______________

Are you here today as a result of the ER visit? ___Yes ___No Who saw you in the ER? (Name)_________________

What test/scans have you had for this problem? ___Xray, ___MRI, ___CAT Scan, ___Bone Scan, ___Nerve Test EMG/NCV

Have you had surgery for a problem in this same area either recently or in the past? ___Yes, ___No, please list below

Procedure #1________________, Surgeon________________, City________________, Date________________

Procedure #1________________, Surgeon________________, City________________, Date________________

Current work status? ___Regular ___Light Duty (How long? _____), ____Not working due to this problem, ___Disabled, ___Retired, ___Student

When is the last date you worked your regular job? ______________________________

MEDICAL HISTORY FORM

C F# ______

Pt. DOB: __________ Family Doctor: ____________________

Patient Name ______________________________

Past Medical History: Please check all that apply

__Anemia
__Asthma
__Bleeding Disorder
__Blood Clots
__Cancer
__Depression
__Diabetes
__Drug/Alcohol Abuse
__Emphysema
__Gout
__Heart Disease
__High Blood Pressure
__High Cholesterol
__HIV/AIDS
__Kidney Disease
__Liver Disease / Hepatitis
__Menopause
__Mental Health Disorders
__Osteoporosis
__Parathyroid Trouble
__Rheumatoid Arthritis
__Seizures
__Sickle Cell Trait / Disease
__Stroke
__Thyroid Trouble
__Ulcers
__Other ______________

Surgical History Procedure(s) and Dates(s)

____

Medication (including dosage and frequency):

____

Drug Allergies and Reaction:

____

REACTION TO ANESTHESIA ? __Yes / __No
(If YES, Please describe reaction)

____

Family History: (Includes all blood relatives)

__Osteoarthritis
__Rheumatoid Arthritis
__Respiratory Disease
__High Blood Pressure
__Bleeding Disorder
__Osteoporosis
__Nerve Disorders
__Muscle Disorders
__Cancer
__Diabetes
__Heart Disease
__Blood Disease
__Gout
__Other ______________

Social History:

Marital History: M S D W
Occupation: ______________
Employer: ______________
Alcohol: __Never __Rarely __Weekly __Daily
Tobacco: __Current __Former Smoker __Nonsmoker
Packs Per Day:____ Number of Years:____ Year Quit:____

Review of Systems:

M/S Have you had *prior problems* with the same orthopedic condition in the past? __Yes __No
Explain: ______________________________
Do *other joints* have __Morning Stiffness __Joint Pain __Joint Swelling __None

Check ALL That Apply or Mark None:

__None __Fever Recurs __Recent Weight Loss
__None __Headache
__None __Worsening Vision __Seeing Double Images __Blurry Vision
__None __Loss of Hearing __Hoarseness
__None __Chest Pain or Discomfort __Palpitations
__None __Difficulty Breathing __Chronic Cough
__None __Decrease in Appetite __Difficulty Swallowing __Heartburn __Nausea
__None __Pain during urination __Urinary Frequency Increased __Blood in Urine
__None __Excessive Thirst __Temperature Intolerance
__None __Dry Skin __Skin Lesions __Skin Rash
__None __Easy Bleeding __Easy Bruising __
__None __Dizziness __Convulsions
__None __Sleep Disturbances __Drug/Alcohol Addiction

FOR OFFICE USE ONLY: New Patient Form - Reviewed for completeness by ______________ Date Reviewed: ________

Nursing Dept. Updates

Date:______ Initials:______ __None __Noted on form
Date:______ Initials:______ __None __Noted on form
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Date:______ Initials:______ __None __Noted on form
Date:______ Initials:______ __None __Noted on form

Reviewed by MD ______ Date ______
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