Beaufort Memorial
ORTHOPAEDIC SPECIALISTS

A BEAUFORT MEMORIAL PHYSICIAN PARTNERS PRACTICE

H. Kevin Jones, MD
Evan C. Reese, MD
Becky Jones, ANP-BC

1251-B RIBAUT ROAD BEAUFORT SOUTH CAROLINA 29902 • (PHONE) 843-524-3015 • (FAX) 843-524-3020

Dear New Patient:

Welcome to our practice! We appreciate the opportunity to help you take care of your healthcare needs and look forward to a long and healthy relationship. Please complete the forms completely and bring them with you to your appointment or return them to us in the enclosed envelope provided; this will speed up your check-in process. **Please arrive 15 minutes before your scheduled appointment time**, so we can get all of your paperwork together and set up your chart for the doctor, unless we have instructed you otherwise.

LOCATION AND HOURS: Our main office is located in Beaufort at 1251B Ribaut Road. Our Bluffton office is located at 11 Arley Way, Suite 102 at Westbury Park, inside the Wells Fargo Building, across the hall from the bank. Our office hours are 8:00 AM to 4:30 PM, Monday—Friday. Please note that we are closed daily for lunch from 12:00 noon until 1:00 PM. **Any correspondence should be mailed to our main office only.**

APPOINTMENTS: If you are unable to keep a scheduled appointment, please give us at least a 24 hour notice. If you are running late, please contact us as we may need to re-schedule you for another time. If you are more that 10 minutes late and we have not heard from you, we will cancel your appointment and ask that you reschedule.

FINANCIAL: Please bring a current picture ID and any active insurance cards with you to your appointment. **For self-paying patients, payment in full is required at the time of service. All co-pays or co-insurances will be collected at check-in.** Please reference the financial policy attached for more information.

MEDICATIONS: Our physicians request that you bring all of your current medications in the original bottles to each appointment or a detailed list. This will ensure accuracy in prescribing and will allow them to manage possible drug interactions.

CELL PHONES: The physicians and staff respectfully request that you turn off your cell phone when in the office.

We look forward to getting to know you and to helping you take the best care of yourself as possible.

Sincerely,

Physicians and Staff of Beaufort Memorial Orthopaedic Specialists.

PLEASE COMPLETE ALL FORMS AND RETURN IN THE SELF-ADDRESSED/STAMPED ENVELOPE ENCLOSED AS SOON AS POSSIBLE.

Updated January 2015

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PATIENT INFORMATION

Name____
LAST FIRST MIDDLE

Address____

____

Home Phone____

Cell Phone____

Work Phone____

Email____

Gender ☐ Male ☐ Female **Race**____________________

Birthdate____

Social Security #____

Primary Language____

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

☐ Full Time Student ☐ Part Time Student ☐ Not A Student

Spouse/Parent Name____

Date of Birth____

Primary Phone____

EMPLOYMENT

Employer____

Address____

____

Phone____

EMERGENCY CONTACT

Name____

Relationship__________________**Phone**____________________

INSURANCE INFORMATION

Primary Insurance

Insurance Co.____

ID/Policy #____

Policyholder's Name____

Policyholder's Birthdate____

Relationship to Patient____

Group Number____

Secondary Insurance

Insurance Co.____

ID/Policy #____

Policyholder's Name____

Policyholder's Birthdate____

Relationship to Patient____

Group Number____

RELEASE OF BENEFITS AND INFORMATION

I authorize benefits to be paid directly to Beaufort Memorial Hospital – Lowcountry Bone and Joint, PA. I understand I am financially responsible for any co-pays, co-insurances, or any non-covered items by my insurance company. I hereby authorize this office and its staff to release any medical or incidental information that may be necessary to other medical care or in the processing of claims for financial benefits.

____

Signature **Date**

REASON FOR VISIT

Primary Complaint / Problem____(**LEFT SIDE**) (**RIGHT SIDE**)

Is this related to an accident / injury / slip and fall ? ☐ Yes ☐ No If yes, what type of accident? (See Below)

☐ MVA (Motor Vehicle Accident ☐ Slip & Fall ☐ Work Comp (See our staff for additional form to complete) ☐ Other

Date of Accident__________________ **State where it occurred**?__________**Attorney Name**____________________

Where you referred by any of the following? ☐ Friend / Family ☐ Internet ☐ Dr. Referral (Who?)__________________

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PATIENT NAME:_______________________________ **DATE OF BIRTH:**_____________________ **AGE:**__________

MEDICAL HISTORY

(Please check any of the following that apply.)

☐ Cancer / Type:___________________________________

☐ Dietary Changes / Explain:___________________________

☐ Diabetes / Type:__________________________________

☐ Depression /Anxiety

☐ Heart Disease / Type:_______________________________

☐ High Cholesterol

☐ Kidney Disease / Type:_____________________________

☐ Hypertension (High Blood Pressure)

☐ Hyperthyroidism (Overactive Thyroid)

☐ Hypothyroidism (Underactive Thyroid)

☐ History of Blood Clots

☐ Pulmonary Embolism (PE)

☐ Lung Disease / Type:_______________________________

☐ Liver Disease / Type:_______________________________

☐ Stomach / GI Problems / Type:_______________________

☐ Sleep Apnea

☐ Rheumatoid Arthritis

☐ Other Major Illness/Injury:___________________________

ALLERGIES

Please list all allergies below to Medications, Foods or Metals (i.e.: Nickel products). Please list reaction that occurs (Rash, difficulty breathing, swelling, etc.)

☐ **NKDA (NO KNOWN DRUG ALLERGIES)**

Allergy:____

Reaction:____

Allergy:____

Reaction:____

FAMILY HISTORY

(This includes: Father, Mother, Grandparents, Siblings)

☐ Cancer / Who:_____________________________________

☐ Diabetes / Who:___________________________________

☐ Heart Disease / Who:_______________________________

☐ High Cholesterol / Who:_____________________________

☐ Hypertension / Who:_______________________________

☐ History of Blood Clots / Who:_________________________

☐ Other:____

____

SOCIAL HISTORY

TOBACCO USE
(Cigarettes, Cigar, Pipe, Tobacco, Recreational Drugs)

☐ Never a Smoker ☐ Former Smoker: How long?_____________

☐ Chew/ Dip ☐ Current Smoker: How much?____________

ALCOHOL USE

☐ None ☐ Occasional ☐ Mild ☐ Moderate ☐ Heavy

MEDICAL HISTORY

Do you have a pacemaker? ☐ No ☐ Yes, see below:

Implant Date________________ Surgeon_________________

Do you have an IVC filter? ☐ No ☐ Yes, see below:

Implant Date________________ Surgeon_________________

Do you have a Stent Placement? ☐ No ☐ Yes, see below:

Implant Date________________ Surgeon_________________

Do you have any type of metal in your body? ☐ No ☐ Yes:

Type____________________ Location___________________

Type____________________ Location___________________

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PATIENT NAME:______________________________ **DATE OF BIRTH:**_____________________ **AGE:**__________

PREVIOUS SURGERIES

Surgery (Type, Body Part)	Location (Medical Facility)	Year

PHARMACY INFORMATION

Name:_____________________________ Location:________________________ Phone:________________________

MEDICATION

Please list any and all Prescriptions and Over the Counter Medications (including vitamins) you are currently taking.

PLEASE ATTACH ADDITIONAL MEDICATION LIST IF NEEDED

Medication Name	Dose	How Often	Reason for Medication

HEIGHT AND WEIGHT

Please provide the following. This enables our physicians to better access your healthcare needs.

Current Weight:__________________________________ Current Height:__________________________________

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PATIENT NAME:______________________________ DATE OF BIRTH:_____________________ AGE:__________

PREFERRED LEARNING METHOD

(Please Circle Answers)

- Method of Learning: Read / Write / Demonstration
- Any Impairments? Hearing / Sight / Mobility
- Any barriers to learning? No / Yes:___________________

ACTIVITIES-SPECIFIC BALANCE CONFIDENTCE SCALE

NO CONFIDENCE (PLEASE CIRCLE) COMPLETE CONFIDENCE

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

1. I can walk around the house: Yes / No
2. I can walk up and down stairs: Yes / No
3. I can bend over and pick up a slipper from the floor: Yes / No
4. I can walk outside the house to a car parked in the driveway: Yes / No
5. I can get into and out of a car: Yes / No

Patient Signature___________________________________ Date______________

Read Score:_____________ (FOR STAFF ONLY)

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Please read and sign the following office policies.

If you have any questions, please ask our staff members to assist you.

APPOINTMENTS: Our office schedule is by appointment only. Please contact our office 24 hours prior to your appointment if you need to cancel or reschedule. If you do no show for an appointment in 3 visits, this office has the right to terminate the physician/ patient relationship.

DISABILITY FORMS: Please allow 10-15 working days for Disability forms to be completed. There is a $25.00 fee for each form and must be paid prior to completion of the forms.

CONTROLLED SUBSTANCE POLICY: I understand the physicians will NOT prescribe controlled substances for an extended length of time, including chronic problems. I will be prescribed pain medication as the physician feels is necessary for the diagnosis for which I am being treated. I understand that if the physician prescribes a controlled substance for me that I may not obtain controlled substances from another physician practice. Failure to notify our office of this is also grounds for termination of the physician/patient relationship. **Medication refill requests take 24-48 hours to process.**

HIPAA AUTHORIZATION: I acknowledge that I have been offered and/or received a copy of the Privacy Practices.

AUTHORIZATON OF RELEASE OF INFORMATION: Can we leave information regarding your appointments, surgery, results, financial or otherwise on your answering machine: ___YES ___NO

Please list those that we may speak to or leave information with on your behalf:

Name:______________________ **Relationship:**________________ **#:**________________

Name:______________________ **Relationship:**________________ **#:**________________

PATIENT RIGHTS: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected information to be disclosed as described in this document by sending written notification to Beaufort Memorial Orthopaedic Specialists. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective forward. I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing the authorization. This authorization shall be in force and effective until revoked by the patient or changed by this practice.

FINIANCIAL RESPONSIBILITY AGREEMENT:

Payment is expected at the time of service. Payment may be made by cash, check or credit card. Any deductible, co-insurance or co-payment is payable at the time of service. Estimates are given for patient responsibility according to contract benefits and are estimates only.

Payment Guarantee: The undersigned agrees, whether signing as a patient or guarantor, to guarantee payment of the account in accordance with the standard rates and terms of Beaufort Memorial Orthopaedic Specialists. I understand that my insurance, if any, is a contract between myself and the insurance company, except in certain cases where Beaufort Memorial Orthopaedic Specialists has a specific contract with my PPO, or third party payer. I further understand that any balance remaining after insurance approves or denies payment is my responsibility to pay, within 120 day from date of service.

In the event the charges incurred are not paid in full when due and collection activity is instituted, whether by a collection agency or an attorney (or both), I agree to be responsible for and pay in addition to the charges for services reasonable collection fees, attorney fees, skip tracing costs, and court costs.

Beaufort Memorial Orthopaedic Specialists reserves the right to transfer unpaid balances to outside entities for collection.

______________________________________ ______________________________

PATIENT / GUARDIAN SIGNATURE **DATE**

STAFF INITIALS: ____________

Updated January 2015

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BODY PART THAT WE ARE SEEING YOU FOR TODAY? ____________________________________

WHICH SIDE ? Left ____ Right ____

IS THIS VISIT DUE TO A WORKERS COMPENSATION OR MOTOR VEHICLE ACCIDENT INJURY?

Yes ___ No ___ State the claim was filed in? ___

Have you had the following annual Vaccinations this year?

Flu Vaccine Yes ___No ___ Date: __________ **Pneumovax** Yes ___ No ___ Date: _________

PATIENTS WHO HAVE BEEN SEEN WITHIN THE LAST YEAR

Have you had any changes in your medication since the last visit? Yes ____ No ____

Has your medical condition changed any since your last visit? Yes ____ No ____

Do you have any new allergies to medications? Yes ____ No ____

Medication: ______________________ Reaction: ___________________

Pain Level (Please Circle) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

Onset of Pain Acute ___ Sudden ___ Gradual ___ Varies ___

How long has this pain been bothering you? Days ___ Weeks ___ Months ___ Years ___

Pattern Intermittent ___ Persistent ___

Severity of Pain No Pain ___ Mild Pain ___ Moderate Pain ___ Severe Pain ___

Course of Pain Increasing ___ Worsening ___ Improving ___ Constant ___ Recurrent ___ No Change ___

Pain is Characterized As: Dull Aching ___ Sharp Stabbing ___ Throbbing ___ Burning Sensation ___ Cramping ___

Aggravating Factors (Please check all that apply)

Exercise ___ Walking ___ Stairs ___ Standing ___ Physical Activity ___ Sports Activity ___

Twisting ___ Squatting ___ Kneeling ___ Weight Bearing ___ Bending ___ Sitting ___ Nothing ___

Pain is relieved by Nothing ___ Rest ___ Heat ___ Ice ___ Medication ___ Elevation ___ Bracing ___

Associated Symptoms (Please check all that apply)

Stiffness ___Joint Swelling ___Redness___ Warmth ___ Weakness ___ Numbness ___ Tingling ___Popping ___

Clicking ___Grinding ___Instability ___ Drainage ___ Radiation Down Leg ___ Painful Range of Motion ___

Image Tests None ___ X-ray ___ MRI ___ CT ___ Bone Scan ___ Nerve Studies ___ Other ___

Have you had any Cortisone Injections for this problem previously? Yes ___ No ___

Did not help ___ Helped temporarily ___ Helped Significantly ___

Have you had Physical Therapy for this problem previously? Yes ___ No ___

Have you had previous Surgery for this problem? Yes ___ No ___ Surgical Procedure __________________

Have you been seen for this problem by any of the following? Emergency Room ___ Neurologist ___

Primary Care ___ Another Orthopaedic Surgeon & Who? ________________________________