Advanced Orthopedics
Nonsurgical & Regenerative Treatments
1658 Pleasure House Rd, Suite 104
Virginia Beach, VA 23455

NEW PATIENT MEDICAL HISTORY

Date: _____
Chart #
Primary Care Physician _____

Patient's Name _____ Ref Physician _____
Date of Birth: __/____/____ Age_____ Weight _____ Height_____ Date of last tetanus _____
Problems with anesthesia† YES † NO If yes, explain _____
Current Conditions _____

Do you have an allergy to chicken and/or eggs or ever been told you should not receive the flu vaccination? † YES † NO

Allergies/Difficulty with Medications	Reaction† None	Current Medication	Dosage † None
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	

Please Check All That Apply To You

PERSONAL MEDICAL HISTORY

No Illnesses	Pneumonia	Bladder/Kidney Infection	Scarlet Fever
Diabetes	Tuberculosis	Arthritis	Bleeding Disorders
High Blood Pressure	Heart Attack or Heart Disease	Cancer	Intestinal Problems
Stroke	Ulcers	Mental or Nervous Disorder	Angina
Emphysema	Hepatitis	Seizures	Heart Murmurs/Valve Problems
Bronchitis	Gallbladder Disease	Venereal Disease	Other
Asthma	Pancreatitis	AIDS/HIV	Specify

SOCIAL HISTORY

Do you smoke cigarettes? † YES † NO
Do you drink alcohol? † YES † NO
Do you take drugs? † YES † NO
Marital Status † Married † Single † Divorced † Separated † Number of Children
Are you † Right Handed † Left Handed
How many hours a day do you stand and/or walk while at work? † 0-1 † 1-3 † 3-5 † 5-8 While at home? † 1-3 † 3-5 † 5-8
Employment: (Type) _____

FAMILY HISTORY (Siblings, parents and children)

		Other (Specify)
__ No Disease	__ Kidney Disease	
Diabetes	Arthritis	
High Blood Pressure	Asthma	
		__ _____
Heart Disease	Seizures	
Cancer	Excessive Bleeding	
__ Tuberculosis	__ Problems with Anesthesia	

REVIEW DATE	
Date	Initial

Physician's Signature _____
R. Michael Graham, MD, FAAOS

Previous Surgery † NONE Dates

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

RECENT DIAGNOSTIC TESTS (Please check all that apply within the last 3-6 months): † NONE

_____Chest X-ray _____ Stress Test ____ Blood Work ____ EKG

REVIEW OF SYMPTOMS (Please check all that apply within the last 3-6 months)

GENERAL † None
Fever
Chills
Night Sweats

ABDOMEN † None
Nausea
Vomiting
Pain and/or Difficulty Swallowing
Gas
Indigestion
Abdominal Pain
__ Bloating
__ Constipation
Diarrhea
Hemorrhoids
Blood Stools

MUSCULOSKELETAL: † None
Fracture
__ Sprain
Strains
Dislocations

HEAD † None
Headaches
Blackouts
Seizures
Dizziness
Double and/or Blurred Vision
__ Ringing Ears
Sinusitis
Post Nasal Drip
Sore Throat
Hoarseness
Cold

URINARY † None
__ Blood in Urine
Burning with Urination
Bladder or Kidney Infection
Frequency and/or Difficulty with Starting Urination
Difficulty with Leaking Urine
Getting Up at Night to Urinate

SKIN † None
Rash
Itching
Psoriasis
__ Change in or Bleeding of Mole

CHEST † None
Cough
Cold
Sputum
Coughing up Blood
Wheezing
__ Shortness of Breath
Chest Pain
Palpitations
Heart Murmur
Swelling of Feet
Rheumatic Fever

NEUROMUSCULAR † None
Joint Stiffness
Joint Pain
Swelling
Back Pain
Varicose Veins
Night Cramps
__ Bursitis
Tendonitis
__ Raynaud's

FEMALE PATIENTS

Do you take Birth Control Pills? † YES † NO
If YES, type _____
Do you take PREMARIN or ESTROGEN or other hormone replacements? † YES † NO
If YES, type _____
Is there any chance you are pregnant? † YES † NO

Advanced Orthopedics
Nonsurgical & Regenerative Treatments
1658 Pleasure House Rd, Suite 300
Virginia Beach, VA 23455
Phone: 757.460.0434 ● Fax: 757.460.0436

OFFICE USE ONLY

ACCOUNT # _____ DR. _____

PLEASE PRINT

PATIENT INFORMATION

PATIENT NAME LAST	FIRST	MIDDLE INT.	SEX	BIRTHDATE	AGE	SOCIAL SECURITY #

HOME ADDRESS STREET	APT. NO	CITY	STATE	ZIP CODE

HOME PHONE	WORK PHONE	MARITAL STATUS
( )	( )	SINGLE DIVORCED MARRIED WIDOWED

EMPLOYED NAME AND ADDRESS	WERE YOU REFERRED BY A PHYISIAN
	YES NO IF SO, WHO: _____

CURRENT PROBLEM	HOW DID YOU HEAR ABOUT OUR PRACTICE	PRIMARY CARE PHYSICIAN AND/OR REF. DR.

REASON FOR VISIT

DATE OF INJURY/SYMPTOMS FOR THIS PROBLEM.	WORK RELATED	AUTO ACCIDENT
	YES NO	YES NO

WERE YOU TREATED FOR THIS PROBLEM AT HOSPITAL YES NO	NAME OF HOSPITAL	WERE X-RAYS TAKEN FOR THIS PROBLEM YES NO WHERE _____

DATE PHYSICIAN FIRST CONSULTED FOR THIS PROBLEM _____	NAME OF YOUR ATTORNEY – IF APPLICABLE

IN CASE OF EMERGENCY CONTACT:	PHONE NUMBER(S)

SPOUSE/GUARANTOR INFORMATION

SPOUSE/GUARANTOR (IF PATIENT IS A MINOR)	HOME PHONE	WORK PHONE
	( )	( )

HOME ADDRESS STREET	APT. NO	CITY	STATE	ZIP CODE

PATIENT'S RELATIONSHIP TO GUARANTOR: SELF SPOUSE DEPENDENT CHILD OTHER	SOCIAL SECURITY #	BIRTHDATE

EMPLOYED NAME AND ADDRESS	

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE COMPANY

INSURANCE COMPANY NAME	SUBSCRIBER NAME (The primary name in which the insurance policy is held)	SEX	SUBSCRIBER DATE OF BIRTH

SOCIAL SECURITY #	PATIENT'S RELATIONSHIP TO GUARANTOR: SELF SPOUSE DEPENDENT CHILD OTHER

INSURANCE ID NO (Member/Certificate)	GROUP NO.	PLAN NO.	EFFECTIVE DATE
			From _____ TO _____

SECONDARY MEDICAL INSURANCE COMPANY

INSURANCE COMPANY NAME	SUBSCRIBER NAME (The primary name in which the insurance policy is held)	SEX	SUBSCRIBER DATE OF BIRTH

SOCIAL SECURITY #	PATIENT'S RELATIONSHIP TO GUARANTOR: SELF SPOUSE DEPENDENT CHILD OTHER

INSURANCE ID NO (Member/Certificate)	GROUP NO	PLAN NO	EFFECTIVE DATE
			From _____ TO _____

PATIENT/GUARANTOR SIGNATURE _____ WITNESS _____ DATE _____

Advanced Orthopedics

Nonsurgical & Regenerative Treatments

1658 Pleasure House Rd, Ste 104, Virginia Beach, VA 23455 Phone: 757-460-0434 Fax: 757-460-0436

I HEREBY CONSENT TO TREATMENT by the Physicians of Advanced Orthopedics - Nonsurgical & Regenerative Treatments, their associates and/or assistants and accept responsibility for fees for such medical services. I understand that treatment may include x-rays, injections, medical appliances, and/or such other procedures as deemed necessary by the physicians at Advanced Orthopedics - Nonsurgical & Regenerative Treatments.

I understand that the payment of copays at the time of service sis required by my insurance company and expected by Advanced Orthopedics - Nonsurgical & Regenerative Treatments and that insurance is filed as a courtesy to me. I understand that I am financially responsible for charges not covered by my insurance. I further understand that if a balance exists on my account at the time of any litigation settlement relating to injuries for which I am being seen, my account with this practice will be the first bill paid and paid in full at the time of the settlement. **Should collection actions become necessary, I understand that I will be liable for any and all costs, including a fifty percent fee for placement with collections, interest at the rate of eighteen percent per annum from the date of treatment, and any attorney fees associated with collecting the unpaid balance owed on my account.**

I hereby authorize the release of any information necessary for filing of any insurance and authorize the assignment of all payments for medical services, for myself or my dependent, to the physicians of Advanced Orthopedics - Nonsurgical & Regenerative Treatments. This authorization is valid for current and subsequent treatment unless I submit a written revocation. A copy of this authorization shall be considered as effective and valid as the original. I will advise Advanced Orthopedics - Nonsurgical & Regenerative Treatments of any changes in insurance coverage. Failure to provide proper notice of insurance that result in denial for timely filing will result in my being responsible for the entire balance.

I also authorize Advanced Orthopedics - Nonsurgical & Regenerative Treatments to speak with and exchange information with other medical professionals regarding my medical condition and treatment. These medical professionals may include, but are not limited to: physical therapists, occupational therapists, athletic trainers, nurses, physician's assistants, rehabilitation specialists, case workers, primary care physicians, referring physicians, and nurse practitioners.

I understand that as a condition of my treatment at Advanced Orthopedics - Nonsurgical & Regenerative Treatments, in the event litigation is required in this case, neither the physician nor the office staff will be available to appear in court. Conferences and/or depositions are scheduled.

If health care workers are accidentally exposed to my blood or body fluids in the course of providing health care to me, I agree to have my blood tested for any infectious disease which might be transmitted to them through this exposure, including HIV/AIDS and hepatitis.

I agree to pay a fee of $25.00 for any check that is returned to the practice for insufficient funds.

I agree that I may be charged and I will pay a $50 fee for any appointment I do not keep without at least 24 hours notice of cancellation.

Signed:_____ _____ _____

Patient or Responsible Party Date Witness

ADVANCED ORTHOPEDICS - NONSURGICAL & REGENERATIVE TREATMENTS

AUTHORIZATION TO **OBTAIN** PROTECTED HEALTH INFORMATION

**** Please Note:** All of the following information must be completed in order to process this request.

Print Patient's Full Name	Birth Date (Mo/Day/Yr)
Street Address	Social Security Number
City, State, Zip Code	Phone Include Area Code

I, _____, authorize the facility named below,

_____

_____

to release my medical records as marked below, dates of ALL, to:

Advanced Orthopedics – Nonsurgical & Regenerative Treatments
1658 Pleasure House Rd, Suite 104
Virginia Beach, VA 23505
Phone: (757) 460-0434 / Fax: (757) 460-0436

____ All clinical notes, except _____ ____ All medical reports, except_____

_____ _____

____ All clinical notes, except _____ ____ All medical reports, except_____

_____

Purpose of Disclosure: _____ medical treatment / continuing care

_____ other (please list) _____

_____

I, _____, authorize disclosure of protected health information on the above named patient. This authorization is valid for 6 months from the date signed. I understand I can revoke this authorization with written notification, but that it will not affect any information previously released prior to the notice of cancellation. I understand the information disclosed may be subject to re-disclosure by the person, persons or facility receiving and would no longer be protected by federal regulations. I understand the medical provider to whom this authorization is furnished may not condition its treatment on me on whether or not I sign the authorization.

Signed:_____ _____ _____

Patient or Responsible Party Date Witness

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS INFORMATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TP) for purposes permitted that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
Your PHI may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT
We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI as necessary, to a home health agency that provides care to you. For another example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT
Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

HEALTH CARE OPERATIONS
We may disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

PLEASE TURN PAGE OVER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of the HIPAA notice of privacy practices and understand that protected health information may be released to other healthcare providers, hospitals, insurance companies, etc. as outlined in the privacy policy.

In general, the HIPAA's privacy rule gives individuals the right to request a restriction on uses and discloses on their protected health information. The individual is also provided the right to request confidential communications.

I wish to be contacted in the following manner:

Home/Cell Phone _____
Authorized to leave a message **Y / N**

Work Phone _____
Authorized to leave a message **Y / N**

May we release information to your family? **Y / N**

Please list any family members that we may release information to:

_____

_____

_____

Please list any family members that we **SHOULD NOT** release information to:

_____

_____

_____ _____
Signature Date