Center of Orthopaedic & Rehab Excellence
Clinton M. Ray, MD
Jeffrey D. Lawler, MD

PATIENT INFORMATION

☐ **REVIEWED/UPDATED INFORMATION**

☐ **REVIEWED/NO CHANGES**

Last Name: _____ First _____ Middle _____ Preferred Name _____

Date of Birth: _____ Social Security # _____ Sex _____ Race _____ Language: _____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Other _____ Email: _____

☐ Student ☐ Retired ☐ Disabled Employer _____ Work # _____

Marital Status: _____ Spouses Last Name: _____ First _____ Phone _____

Home Address: _____ City _____ St _____ Zip _____

Billing Address: _____ City _____ St _____ Zip _____

Home Ph#: _____ Cell # _____ Appointment Reminder Options: ☐ Text ☐ Email ☐ Both

Responsible Party: _____ Relationship _____ DOB _____ Ph _____

Mailing Address (if different than patient) _____ City _____ St _____ Zip _____

Emergency Contact (Outside of Home) _____ Relationship _____ Ph _____

Is patient in a Nursing or Long Care Facility / Rehab Facility: ☐ Yes ☐ No *If Yes,* where? _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Contract # _____ Group # _____

Subscriber Name: _____ Birthdate: _____ Relationship: _____

Employer: _____ Address: _____ Ph: _____

Secondary Insurance Company: _____ Contract # _____ Group # _____

Subscriber Name: _____ Birthdate: _____ Relationship: _____

Employer: _____ Address: _____ Ph: _____

CONSENT FOR TREATMENT: I consent to necessary treatment, including medications, x-rays, or other studies that may be used by the attending physician, or clinical staff of CORE Orthopaedics & Sports Medicine.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize CORE Orthopaedics & Sports Medicine to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my case, or my employer who is providing payment of my medical bills due to an on the job injury.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to CORE Orthopaedics & Sports Medicine of benefits that otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the CORE Orthopaedics & Sports Medicine charges for these services. I understand that I am financially responsible to CORE Orthopaedics & Sports Medicine for charges not covered by this assignment.

GUARANTEE OF ACCOUNT: For services furnished by CORE Orthopaedics & Sports Medicine, I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services, I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary all costs of collection, including interest and attorney's fees.

NO SHOW/CANCELLATION POLICY: There will be a minimum charge of $25.00 for all patients who miss an appointment without giving a 24 hours (one business day) notice. The $25.00 No Show/Non-Cancellation fee must be paid by each individual prior to or on the next appointment at our office. If you no show for your appointment 3 consecutive times or if you cancel less than 24 hours in advance 5 consecutive times, you will not be allowed to schedule future appointments.

COLLECTIONS & FINANCE POLICY: All unpaid accounts over 120 days will incur an additional 36% interest charge and be turned over to collections. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance coverage and benefits.

SIGNATURE _____ **RELATIONSHIP** _____ **DATE** _____

HEALTH HISTORY

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Name _____ DOB _____ Age _____ Referring Provider _____

Date of injury: _____ OR Duration of symptoms _____ days _____ mos _____ yrs

Description of Injury/Symptoms: _____

INJURY / SYMPTOMS

Work Comp Related: ☐ Yes ☐ No Employer: _____

Motor Vehicle Accident: ☐ Yes ☐ No What State did Accident Occur: _____

Pending Litigation or Lawsuit: ☐ Yes ☐ No Attorney Name: _____

Has the injury/symptom(s) affected any normal or everyday activities?

☐ Driving ☐ Household Chores ☐ Eating ☐ Sitting / Standing Long Periods of Time

☐ Dressing ☐ Personal Hygiene (Bathing / Grooming) ☐ Walking ☐ Climbing Stairs

☐ Squatting ☐ Other Difficulties in Functional Mobility: _____

DIAGNOSTIC

Diagnostic Test(s) Performed: ☐ Yes ☐ No Where Performed: _____

☐ MRI ☐ X-ray(s) ☐ Bone Scan ☐ CT ☐ Nerve Conduction

Other: _____

ORTHOPEDIC HISTORY

Previous Orthopedic Surgeries / Approx. Date(s): ☐ N/A

_____

Previous Physical Therapy or Supervised Home Exercise Plan ☐ Yes ☐ No

Reason for Physical Therapy / Approx. Date(s): ☐ N/A _____

Previous / Current Use of Bracing / Approx. Date(s): ☐ N/A _____

Previous / Current Medications for Bone / Joint Conditions: ☐ N/A _____

Previous Muscle / Joint Injection Treatment(s) / Approx. Date(s): ☐ N/A _____

Currently in Pain Management Care ☐ Yes ☐ No Provider Name: _____

Reason(s) for Pain Management: ☐ N/A _____

OTHER MEDICAL

Pregnant or Nursing: ☐ Yes ☐ No ☐ Not Applicable

Tobacco Use:

☐ Yes ☐ No ☐ Cigarettes ☐ Pipe ☐ Smokeless Per Day _____ Start Date _____ Quit Date _____

Alcohol Use: ☐ Yes ☐ No ☐ Occasional Per Day _____ Per Week _____

Other Previous Surgeries / Approx. Date(s): _____

_____

List Current Medications: ☐ None _____

_____

List All Allergies: ☐ N/A _____

_____

PREFERRED PHARMACY _____ **LOCATION** _____ Height _____ Weight _____ BMI _____

PATIENT'S SIGNATURE _____ **PHYSICIAN SIGNATURE** _____ **DATE** _____

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REVIEW OF SYSTEMS

Name _____ DOB _____ Age _____ Referring Provider _____

Please select yes or no if you are ***currently*** having any of the following:

CONSTITUTIONAL SYMPTOMS

Are you in good general health	☐ YES	☐ NO
Recent weight change	☐ YES	☐ NO
Fever	☐ YES	☐ NO
Fatigue	☐ YES	☐ NO
Headaches	☐ YES	☐ NO

CARDIOVASCULAR

Heart trouble	☐ YES	☐ NO
Chest pain or angina pectoris	☐ YES	☐ NO
Palpitation	☐ YES	☐ NO
Shortness of breath	☐ YES	☐ NO
Swelling of feet, ankles, hands	☐ YES	☐ NO

RESPIRATORY

Chronic or frequent coughs	☐ YES	☐ NO
Spitting up blood	☐ YES	☐ NO
Asthma	☐ YES	☐ NO

GASTROINTESTINAL

Loss of appetite	☐ YES	☐ NO
Change/pain in bowel movements	☐ YES	☐ NO
Nausea or vomiting	☐ YES	☐ NO
Frequent diarrhea	☐ YES	☐ NO
Constipation	☐ YES	☐ NO
Rectal bleeding or blood in stool	☐ YES	☐ NO
Abdominal pain or heartburn	☐ YES	☐ NO

PSYCHIATRIC

Memory loss or confusion	☐ YES	☐ NO
Nervousness	☐ YES	☐ NO
Depression	☐ YES	☐ NO
Insomnia	☐ YES	☐ NO

MUSCULOSKELETAL

Joint pain	☐ YES	☐ NO
Joint stiffness or swelling	☐ YES	☐ NO
Weakness of muscle or joints	☐ YES	☐ NO
Muscle pain or cramps	☐ YES	☐ NO
Back pain	☐ YES	☐ NO

INTEGUMENTARY

Rash or itching	☐ YES	☐ NO
Change in skin color	☐ YES	☐ NO
Varicose veins	☐ YES	☐ NO

ENDOCRINE

Glandular or hormone problem	☐ YES	☐ NO
Thyroid disease	☐ YES	☐ NO
Excessive thirst or urination	☐ YES	☐ NO
Heat or cold intolerance	☐ YES	☐ NO
Skin becoming dryer	☐ YES	☐ NO

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	☐ YES	☐ NO
Bleeding or bruising tendency	☐ YES	☐ NO
Anemia	☐ YES	☐ NO
Phlebitis	☐ YES	☐ NO
Past transfusions	☐ YES	☐ NO
Auto Immune disorder	☐ YES	☐ NO

GENITOURINARY

Frequent urination	☐ YES	☐ NO
Burning or painful urination	☐ YES	☐ NO
Blood in urine	☐ YES	☐ NO
Kidney stones	☐ YES	☐ NO

PATIENT'S SIGNATURE _____ **PHYSICIAN SIGNATURE** _____ **DATE** _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

HIPAA INFORMATION

I, _____ Date of Birth _____
(PRINT – Patient's Full Name)

AUTHORIZE: ALL PHYSICIANS AND STAFF OF CLINTON M.RAY, M.D. ORTHOPAEDICS & SPORTS MEDICINE:
(Please check ALL that apply & PRINT Name(s) for each section) or **check "NONE" if not applicable.**

I. TO DISCUSS MY **MEDICAL TREATMENT AND CONDITION** WITH:

☐ Patient's Spouse: _____

☐ Patient's Parent(s): _____

☐ Other (Specify Name(s) & Relationship): _____

☐ NONE

PURPOSE OF DISCLOSURE IS TO: **Allow Discussion of my Medical Treatment and Condition.**
THIS AUTHORIZATION IS EFFECTIVE FOR ***ONE YEAR*** AFTER I CEASE MEDICAL TREATMENT WITH CLINTON M.RAY, M.D. ORTHOPAEDICS & SPORTS MEDICINE, LLC.

II. TO DISCUSS **FINANCIAL / ACCOUNT INFORMATION** WITH:

☐ Patient's Spouse: _____

☐ Patient's Parent(s): _____

☐ Other (Specify Name(s) & Relationship): _____

☐ NONE

PURPOSE OF DISCLOSURE IS TO: **Allow Discussion of my pertinent Financial/Account Information.**
THIS AUTHORIZATION IS EFFECTIVE FOR ***TWO YEARS*** FOLLOWING SATISFACTION OR PAYMENT OF ALL BALANCES OWED TO CLINTON M.RAY, M.D. ORTHOPAEDICS & SPORTS MEDICINE, LLC.

III. ***TO ALLOW PICK UP of PRESCRIPTIONS (Rx's)
***No one may be allowed to pick up prescriptions other than the patient or authorized person(s) below.

☐ Patient's Spouse: _____

☐ Patient's Parent(s): _____

☐ Other (Specify Name(s) & Relationship): _____

☐ NONE

PURPOSE OF DISCLOSURE IS TO: **Allow Discussion of my Medical Treatment and Condition.**
THIS AUTHORIZATION IS EFFECTIVE FOR ***ONE YEAR*** AFTER I CEASE MEDICAL TREATMENT WITH CLINTON M.RAY, M.D. ORTHOPAEDICS & SPORTS MEDICINE, LLC.

You may request a copy of this authorization. You have the right to revoke this authorization at any time in WRITING. Revocation will not apply to information that has already been released in response to this authorization. Revocation will not apply to your insurance company when the law provides your insurer with the right to contest a claim under your policy. The information disclosed may be subject to re-disclose by the recipient and no longer protected by law. Treatment, payment, enrollment in a health plan or eligibility for benefits is not based on the provision that you sign this authorization. You may refuse to sign this authorization.

Signature of Patient or Legally Authorized Person _____ Date _____

If signed by other Legal Authorized Person, indicate Relationship to Patient _____

NOTICE OF PRIVACY PRACTICES

☐ ACCEPT PRIVACY PRACTICES

I, _____ Date of Birth _____,
(PRINT- Patient's Full Name)

acknowledge that I have been provided or can request a copy of the Notice of Privacy Practices of Privacy Practices of CORE Orthopaedics & Sports Medicine, LLC to read, and I agree with these policies. I also acknowledge my right to request a copy in writing at any time.

Signature of Patient or Legally Authorized Person _____ Date _____

If signed by other Legal Authorized Person, indicate Relationship to Patient _____

☐ DECLINE PRIVACY PRACTICES

You have the right to refuse signature to agree with the Privacy Practices of CORE Orthopaedics & Sports Medicine, LLC.
Please sign below ONLY If you refuse to sign above agreeing with our policies.

Signature of Patient or Legally Authorized Person _____ Date _____

If signed by other Legal Authorized Person, indicate Relationship to Patient _____