



UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE

UNIVERSITY SPECIALTY CLINICS®

Thank you for scheduling an appointment with one of our physicians. It is our pleasure to welcome you to the Department of Orthopaedic Surgery and Sports Medicine in advance of your first visit.

The clinic is located at **Two Medical Park, Lower Level, Suite L10.**

Below are important items you need to look over prior to your first visit to our practice. Some require action on your part.

Insurance Coverage: Please bring your insurance card to your scheduled appointment. Without verification of your insurance coverage your appointment may be rescheduled, or you will be expected to pay all fees at the time services are rendered. If your insurance carrier requires referral authorizations, it is your responsibility to check with your primary care physician to ensure they have authorized your visits to your office. Without this authorization you will be expected to pay for the services you receive, on the date of your appointment, in full.

Medical Information: Please have your medical records forwarded to us prior to your appointment. We need to review these records which may include x-rays, MRI's, bone scans, and notes of visits to other physicians.

Please bring with you all medications you are currently taking so we can accurately document this information in your patient chart.

Medical History Forms: Attached you will find medical history forms with need to be completed prior to your visit at our office. These forms, completed in entirety, are required in our office prior to being seen by any of our physicians. You may either bring the completed forms with you on the day of your appointment or mail them if time allows.

Minors under the Age of 18: Patients that are under the age of 18 must be accompanied by a parent/legal guardian. If a parent/legal guardian is unavailable to attend the visit, the form *Consent to Medical Treatment and Responsibility for Medical Charges for Minors* must be filled out and given at time of check in.

Any of the above information that is missing on the day of your schedule appointment may cause a reschedule of your appointment. Please arrive **30 minutes** prior to your scheduled appointment time. If you have any questions prior to your visit, please contact our office by calling 803-434-6812.

Internet-kjh-1-07-09

DEPARTMENT OF ORTHOPAEDIC SURGERY
Two Medical Park, Suite 404, Columbia, SC 29203
803-434-6812, FAX 803-434-7306
www.uscortho.com/www.uscsportsmedicine.com



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PLEASE PRINT CLEARLY

DATE _____

(Information About You)

Full Name _____ Marital Status: S M D W
 Street Address _____ City _____ State _____ Zip _____
 Mailing Address _____ City _____ State _____ Zip _____
 Email Address _____
 Employer/School _____ Occupation _____
 Employer Address _____ City _____ State _____ Zip _____
 Home Phone # _____ Work Phone # _____ Cell Phone # _____
 Date of Birth _____ Social Security # _____ Driver's License # _____
 Nearest Relative Not Living With You _____ Phone # _____
 Primary Care Physician: _____ Referred to this office by: _____
 Do You Have Medical Insurance? Yes No Do You Live In A Skilled Nursing Facility? Yes No

(Information About Your Parent/Spouse)

Parent/Spouse's Full Name _____
 Parent/Spouse's Employer _____ Occupation _____
 Employer Address _____ City _____ State _____ Zip _____
 Parent/Spouse DOB _____ Social Security # _____ Work Phone # _____

PRIMARY INSURANCE TO FILE

Policy # _____ Group # _____
 Insured's Name _____ Relationship to Patient _____
 Insured's Social Security # or ID # _____ Insured's DOB _____
 Insurance Co. Name _____ Insurance Co. Phone # _____
 Insurance Co. Address _____ City _____ State _____ Zip _____

SECONDARY INSURANCE TO FILE

Policy # _____ Group # _____
 Insured's Name _____ Relationship to Patient _____
 Insured's Social Security # or ID # _____ Insured's DOB _____
 Insurance Co. Name _____ Insurance Co. Phone # _____
 Insurance Co. Address _____ City _____ State _____ Zip _____

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize this authorization allows USCSOM Department of Orthopaedic Surgery to release any information to any of my insurers or physicians as requested by any such insurer or physician.

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS TO WHICH I AM ENTITLED INCLUDING MEDICARE, PRIVATE INSURANCE, GROUP POLICY BENEFITS AND OTHER HEALTH PLANS TO USCSOM DEPARTMENT OF ORTHOPAEDIC SURGERY. USCSOM DEPARTMENT OF ORTHOPAEDIC SURGERY DOES NOT EXTEND CREDIT. I HEREBY AGREE TO PAY ALL COSTS AND REASONABLE ATTORNEY FEES IN THE EVENT THIS ACCOUNT IS TURNED OVER TO AN ATTORNEY FOR COLLECTION.

Signature _____ Date _____
 Responsible Party Signature (if different)



In order to better coordinate your health care needs and ensure other physicians involved with your care are updated regarding your medical condition(s), please provide the following information:

REFERRING PHYSICIAN: (Who referred you to our practice?)

Doctor's Name: _____
 Doctor's Address: _____

 Doctor's Phone #: _____
 Doctor's Fax #: _____
 Doctor's Specialty: _____
 Would you like us to send copies of your medical records? YES NO

PRIMARY CARE PHYSICIAN/FAMILY PRACTICIONER:

Doctor's Name: _____
 Doctor's Address: _____

 Doctor's Phone #: _____
 Doctor's Fax #: _____
 Doctor's Specialty: _____
 Would you like us to send copies of your medical records? YES NO

SPECIALIST: (Cardiologist, Internal Medicine, Ob/Gyn, Dermatologist, etc.)

Doctor's Name: _____
 Doctor's Address: _____

 Doctor's Phone #: _____
 Doctor's Fax #: _____
 Doctor's Specialty: _____
 Would you like us to send copies of your medical records? YES NO

ORTHOPAEDIST: (Have you seen any other Orthopaedic Physician?)

Doctor's Name: _____
 Doctor's Address: _____

 Doctor's Phone #: _____
 Doctor's Fax #: _____
 Doctor's Specialty: _____
 Would you like us to send copies of your medical records? YES NO

Patient Signature

Social Security Number

Date

Patient Name (Printed)



MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date of Birth _____
Social Security # _____ Referring Physician _____

History of Present Illness

Please explain your current problem. Include location of problem, how long you have experienced this problem, and the severity of the problem. Include what makes the problem worse or better and any associated signs or symptoms.

Past History

List any medications you presently take: _____

List all illness/injuries/surgeries you have had that required hospitalization: _____

Do you have allergies to any medications? YES NO

If yes, list medications you are allergic to: _____

Are you allergic to Latex? YES NO

Family History

Disease	Family Member		Disease	Family Member

Social History

Current Occupation _____

Do You Drive? YES NO

Do You Drink Alcohol? YES NO If yes, how often? _____

Do You Smoke/Chew Tobacco? YES NO If yes, how much a day? _____

Do You Do Drugs? YES NO If yes, what kind? _____



Review of Systems (Please check box if Yes)

Patient Name: _____

General	Gastrointestinal	Genitourinary
<input type="checkbox"/> Weight Change	<input type="checkbox"/> Dysphagia (problems swallowing)	<input type="checkbox"/> Urinary Infections
<input type="checkbox"/> Fever or Chills	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Urinary Frequency	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Menopause
<input type="checkbox"/> Bleeding		
<input type="checkbox"/> Lumps or Masses	Cardiovascular	Neurologic
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Heart DX/Pain	<input type="checkbox"/> Seizures
<input type="checkbox"/> Itching/Rash	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Numbness
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Thrombophlebitis	<input type="checkbox"/> Weakness
<input type="checkbox"/> Cancer		
Ear-Eyes-Nose-Throat	Respiratory	Musculoskeletal
<input type="checkbox"/> Visual Change	<input type="checkbox"/> Cough/Sputum	<input type="checkbox"/> Backache
<input type="checkbox"/> Hearing Change	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Joint Pain
<input type="checkbox"/> Tinnitus (ringing in ears)	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Joint Swelling
<input type="checkbox"/> Dentures	<input type="checkbox"/> Pleurisy/Pneumonia	
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Shortness of Breath	Skin
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bruises Easily
<input type="checkbox"/> Sneezing		<input type="checkbox"/> Sores
		<input type="checkbox"/> Rashes/Lesions
Breast		
<input type="checkbox"/> Lumps, Pain, Nipple Discharge		

Explain all "YES" answers here:

***OFFICE USE ONLY**

Physician Signature

Date Physician Reviewed

Above History Updated (initial and date all changes to above information):

Date	Physician Signature	Date	Physician Signature



Patient Name: _____

Please answer, yes or no, to the following questions as they pertain to pre-authorization for anti-inflammatory therapy.

1. Have you required Nonsteroidal anti-inflammatory therapy for more than 21 consecutive days?
 YES NO

2. Have you experienced intolerance with at least 2 other anti-inflammatory medications? (i.e. Motrin, Aleve, Advil, Naprosyn, etc.)
 YES NO

3. Do you have a history of peptic ulcer disease, Nonsteroidal anti-inflammatory related ulcer, GI bleed, or coagulation defect?
 YES NO

4. Are you receiving drug therapy with corticosteroids, anticoagulants, antiplatelets, or methotrexate?
 YES NO

5. Are you currently receiving an H2 antagonist, proton pump inhibitor, or misoprostol (Cytotec)? (i.e. Prevacid, Zantac, Prilosec, etc)
 YES NO



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Authorization Regarding Payment and Release of Medical Information

I hereby authorize and request the payment of services from Medicare, Medicaid and/or other insurance plans or payers be made on my behalf to University Specialty Clinics-Department of Orthopaedic Surgery. I hereby assign to University Specialty Clinics all payments for treatment services. I understand and agree that I am responsible for paying any amount not covered by Medicare, Medicaid and/or other insurance plans or payers.

I hereby authorize the release of medical information to Medicare, Medicaid and/or insurance plans or other payers. I also authorize the release of medical information to other healthcare providers including, but not limited to, my primary care or family physician, consulting physicians or healthcare providers, hospitals, rehabilitation centers, or other healthcare providers or facilities. I permit a copy of this authorization to be used.

Patient's/Patients Representative's Signature

Witness Signature

Date

Date

Printed Patient's or Representative's Name

Representative's Relationship to Patient



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Consent to Treatment

I hereby agree to and give consent to the physicians, healthcare providers, associates, consultants and residents of University Specialty Clinics to diagnose and treat me. I consent to any and all treatment including, but not limited to, physical examinations, psychological examination, x-rays, laboratory procedures, and other procedures related to routine diagnosis and treatment as determined appropriate by the practices physicians, healthcare providers, associates, consultants and residents.

Patient's/Patients Representative's Signature

Witness Signature

Date

Date

Printed Patient's or Representative's Name

Representative's Relationship to Patient

kh 1-7-09



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University Specialty Clinics Notice of Privacy Practices

By signing below, I state that I have been given my own copy of the University Specialty Clinics' Notice of Privacy Practices, effective date 4/14/03.

Printed Name of Patient

Signature of Patient

Date

OR

Printed Name of Patient's Representative

Signature of Patient's Representative's

Date

Description of Authority to Act on Behalf of Patient

Effective Date 4-14-03