

Patient Medical History **Date** _____

Height: _____ Weight: _____

Family Members seen in this office: _____

Primary Care Physician: _____

Who requested you visit the office? _____ MD Coach Family ER Other: _____

Which body part have you scheduled for treatment? Please circle.

Toe	Heel	Foot	Ankle	Leg	Hand	Knee	Thigh	Hip	Back	Neck	Shoulder	Clavicle
Arm	Elbow	Wrist	Finger	Other:								
			<input type="checkbox"/> Right		<input type="checkbox"/> Left		<input type="checkbox"/> Bilateral					

Name of School/Team: _____ Coach's Name: _____

Date of Injury: _____ If injury, explain where and how it occurred: _____

Describe symptoms: _____

Severity What is the severity of your pain? (scale of 0-10) _____

Quality What is the **quality** of your pain? Sharp Dull Stabbing Throbbing Aching Burning

Timing The pain is: Constant Intermittent Does your pain wake you from sleep? yes no

Context Since my problem started, it is: Getting Better Getting Worse Unchanged

Assoc. Symp Do you have? Swelling Bruising Numbness Tingling Weakness

Modify What makes your symptoms **worse**? Standing Walking Lifting Exercise
 Twisting Bending Squatting Kneeling Stairs Sitting Coughing/Sneezing

Which makes your symptoms **better**? Rest Elevation Ice Heat Other: _____

What medications are you taking now (or previously) for this problem? _____

Have you been treated for this condition? yes no Treating Physician/ER? _____

Describe treatment.

For Office Use

X-ray findings: negative mild / mod DJD type I / II / III no/mild / mod AC grade I/II/III buckle progressive stable alignment _____

Codes: NC/ MDC/ 03 / 04 / 13 / 14 / 24 / 25 / 43 / 45 / 73 Modifiers: 25 / 24 / 50 / 51 / 58 / 55 / 57 / 58 / 78 / 79

Follow Up: ____ days / 1w / 2w / 3w / 4w / 6w / 8w / 3m / 4m / 6m / 1y / prn / MRI / bone scan / pre-op / post / md to call / pt to call / sidelines / injury

PT: AFPT/ NV Sugar / Dacula / Lville Lanier / Morris / Sportscore / Promina / CHOA/ AtlRehab / Home / Other: _____

Medications: V / pred / perc / Lort / _____ Injection: Sub / AC / Glen / Knee / Wrist / Ankle / trigger / tendon / Supartz

MRI: R / L arthro Closed / Open S / K / A / W / Neck / Back Other: _____

Bone Scan: back with spect / LE / Foot / Wrist

Supplies: wrist splint / boot / lace up / air cast / finger / cast shoe / heel / _____ Casts: SA / LA / sleg / walker / llig / splint / gortex

One Source: exchange / fusion / ultra / shoulder stabilizer _____

Referrals: epidurals / facets / sympathetic/ EMG / NCV MD / other: _____

Notes: coaches / work / school / gym Follow up X-ray Out of cast

Past Medical History

Please circle if you have had problems with or are presently complaining of any of the following:

- | | |
|------------------------|-----------------------------------|
| 1. High Blood Pressure | 10. Peptic Ulcers |
| 2. Diabetes | 11. Gastric Reflux |
| 3. Cancer | 12. Irritable Bowl/Chrons Disease |
| 4. Heart Disease | 13. Hepatitis |
| 5. Heart Arrhythmia | 14. Kidney Stones |
| 6. Stroke | 15. DVT / PE |
| 7. Thyroid Disease | 16. Migraine Headaches |
| 8. COPD | 17. Rheumatoid Arthritis |
| 9. Gout | 18. Others: (Please Explain) |

Previous Hospitalizations/Surgeries/Serious Illnesses:

When

Location

<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

List present medications (include non-prescription drugs)

List Medication Allergies: PCN Sulfa Drugs Erythromycin Codeine Others: _____

Personal History: Married Single

Tobacco Use: Never smoked >½ pack a day ½ a pp d 1 pp d 2 ppd More than 2 ppd

Date stopped smoking: ____ / ____ / ____ Any other drugs? List: _____

Alcohol use: Never drink Rarely drink Drink socially Drink daily: _____

Family History

Has any blood relative had any of the following: (Circle yes or no, leave blank if uncertain)

Cancer yes no

Diabetes yes no

Heart Disease yes no

High Blood Pressure yes no

Rheumatoid Arthritis yes no

Tuberculosis yes no

Other (Please Comment): _____

Relationship/Comments

List:

Work Status:

Regular Light Duty (How long _____) Not Working Due to This Problem Retired Student

Are you currently receiving or planning to apply for: Disability Workers Compensation yes no

Do you have an attorney or plan to get an attorney? yes no Name: _____



Review of Systems

I have no problems or changes in these areas since my last office visit

GI	None <input type="checkbox"/>	Heartburn/Ulcers	Nausea/Vomiting
Cardiac	None <input type="checkbox"/>	Chest Pain	Palpitations
Respiratory	None <input type="checkbox"/>	Shortness of Breath	Chronic Cough
Musculoskeletal	None <input type="checkbox"/>	Swelling in Extremity	Increased Weakness
General	None <input type="checkbox"/>	Fever/Chills	Rashes
Neurological	None <input type="checkbox"/>	Numbness/Tingling	Radicular Pain
Hematology	None <input type="checkbox"/>	Pulmonary Embolus	Deep Venous Thrombosis
GU	None <input type="checkbox"/>	Blood in Urine	Kidney Stones
Psychiatric	None <input type="checkbox"/>	Depression	Sleep Disturbances
ENT	None <input type="checkbox"/>	Sore Throat	Hearing Change
Eyes	None <input type="checkbox"/>	Blurry Vision	Double Vision
Endocrine	None <input type="checkbox"/>	Hormonal Problems	Heat or Cold Intolerance
Allergy	None <input type="checkbox"/>	New Drug Allergy	Specify:

Past Medical History:

Have you been prescribed any new medications or changed any medications since your last visit?
(yes or no)

Past Medical History:

What is your current job status?

- Do Not Work
- Regular Duty
- Light Duty
- Not Working Due to this Condition

When do you expect to return to full duty?

When do you expect to return to work?

Signature: _____ Date: _____
Patient/Guarantor



Mark C. Cullen, M.D.

Patient Information:

Name (Last, First, Middle)	SSN #	Sex
<input type="text"/>	<input type="text"/>	<input type="text"/>
Local Address	Birth Date	
<input type="text"/>	<input type="text"/>	
City, State, Zip	E-mail Address	
<input type="text"/>	<input type="text"/>	
Home Phone	Pharmacy	
<input type="text"/>	<input type="text"/>	
Cell Phone	Pharmacy Phone Number	
<input type="text"/>	<input type="text"/>	
Your Primary Employer	Policy Holder Name	
<input type="text"/>	<input type="text"/>	
Address	Date of Birth	
<input type="text"/>	<input type="text"/>	
City, State, Zip	Place of Employment	
<input type="text"/>	<input type="text"/>	
Work Phone		
<input type="text"/>	<input type="text"/>	

Family members seen by this Doctor:

Referred By:

Primary Care Physician:

Emergency Contact Name:

Relationship:

Home Phone:

Cell Phone:

Please be prepared to pay for office visits at the time of your appointment. Our office accepts cash, check, or credit card.

How do you plan to pay for today's services (please circle): cash check credit card (Visa or MasterCard)

If fees are incurred in order to collect any delinquent accounts those fees will be the responsibility of the patient.

I hereby apply and consent to today's visit and all subsequent visits to Admission and Treatment by Georgia Sports Medicine, LLC staff and authorize all routine office procedures and services, treatment, examination, and diagnostic procedures, including but not limited to the use of x-rays, laboratory testing, drugs, or procedures as well as release of medical data and/or copies to other agencies and/or physicians I may be referred to for follow-up care as may be ordered by the Doctor. I also certify that no guarantee or assurance have been made as to the results that may be obtained.

I hereby authorize Georgia Sports Medicine to release any of information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and health practitioners.

I authorize and request that my insurance company assign payment directly to Georgia Sports Medicine for services rendered to me or my dependent. I understand that I am responsible for all charges regardless of insurance coverage. I understand that it is my responsibility to verify covered benefits with my carrier, obtain proper referrals and pay the treating physician deductibles and co-insurance amounts.

I give consent for myself/son/daughter/spouse to under go examination, x-ray and treatment by Georgia Sports Medicine.

I understand my signature requests payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of HCA: 1500 claim form is completed, (secondary insurance box), my signature authorizes releasing of the information to the agency above.

Signature: _____ **Date:** _____



Patients of Georgia Sports Medicine

Due to our contractual agreements with insurance companies and State Law, all co-pays **MUST** be collected at the time of service.

All deductibles **must** also be collected after filing with your insurance.

Failure to pay the designated co-pay amount set by your insurance company will result in an additional charge. We will be enforcing a non-payment of co-pay fee. This fee will be an additional charge added to your total for those particular day's charges. This fee does not waive your co-payment.

Fees are as follows:

Non-Payment of Co-Pay		\$15.00
Returned Check Fee		\$25.00
No Show Appointment Fee	1 st Offense	\$25.00
	2 nd Offense	\$50.00
	3 rd Offense	Dismissal

No appointments will be scheduled until fees are paid in full.

Copy of X-Rays	\$20.00 (Disc)
	\$10.00 (Page)
Copy of Medical Records	\$1.00 a page 1-25
	\$0.50 a page 26-50
	\$0.25 a page 51-75
	No charge 75+ pages
Completion of All Paperwork (FMLA, AFLAC, Disability, etc.)	\$25.00

***All Copies and Paperwork will be completed 10-14 business days from time of signed request received.**

Signature: _____ Date: _____
Patient/Guarantor