Dear Valued Patient,

Thank you for choosing the Bone & Joint Institute of South Georgia for your orthopaedic needs. Your patient experience is of the utmost importance to us. In an effort to reduce waiting room times, we have provided a new patient packet for you to complete in advance of your appointment. Please fill out all of the enclosed forms and bring them with you to your appointment along with:

- Your Insurance Card
- A Picture ID
- Any disks with MRI, CT Scans, or Xray images

Please call our office at 912-427-0800 with any questions. We are looking forward to your visit.

Sincerely,

Nancy Freeman
Business/Front Office Manager

Enclosures
PATIENT INFORMATION

PATIENT DEMOGRAPHICS

Patient Name: _______________________________ Date of Birth: ___________________________ Age: __________

FIRST MI LAST

SSN: __________________________ Gender: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race: _______________________________ Ethnicity: _______________________________

Do you currently reside in a nursing facility? ☐ YES ☐ NO

If Yes: Name of Facility: _____________________________________________________________

Home Address: ________________________________________________________________

City: __________________________ State: ______ Zip: __________

Mailing Address (IF DIFFERENT FROM ABOVE):

City: __________________________ State: ______ Zip: __________

Home Phone: __________________ Work Phone: ___________________ Cell Phone: __________

Employer: __________________________ Employer Phone#: __________________________

May we leave information on your answering Machine or Voicemail? ☐ YES ☐ NO

Email Address: __________________________

PRIMARY CARE/REFERRING PHYSICIAN

Primary Care Physician: __________________________ Referring Physician: ______________

EMERGENCY/NEXT OF KIN CONTACT INFORMATION

Name: __________________________ Phone: __________ Relationship to Patient: ______________

PARENT OR GUARDIAN RESPONSIBLE FOR BILL

Name: __________________________ Date of Birth: __________ SSN: __________________________

Home Phone: __________________ Work Phone: ___________________ Cell Phone: __________

Relationship to Patient: __________________________

Mailing Address: ________________________________________________________________

City: __________________________ State: ______ Zip: __________

BE SURE TO FILL OUT PAGE (2) OF THIS FORM.

OFFICE USE ONLY

New Patient Brochure

☐ YES ☐ NO

PATIENT’S INITIALS

JESUP 110 Professional Court, P.O. Box 1334, Jesup, Georgia 31545 | BAXLEY 1093 W. Parker Street, Suite A, Baxley, Georgia 31513

HINESVILLE 475 S. Main Street, Suite A, Hinesville, Georgia 31313 | WAYCROSS 1912 Memorial Drive, Suite D, Waycross, Georgia 31501

Toll Free (866) 806-0800 | Phone (912) 427-0800 | Fax (912) 427-6029 | www.BJISG.com

August 28, 2017
PRIMARY INSURANCE INFORMATION

Name of Insurance Co: _____________________________
Address of Insurance Co: _____________________________
Policy#: ___________ Group#: ___________ Insured Relationship to Patient: ___________
Insured Name: ___________________________ Insured DOB: ________ Insured SSN: ___________
Insured Mailing Address: _____________________________
City: _____________________________ State: ___________ Zip: ___________
Insured Phone#: ___________________________

SECONDARY INSURANCE INFORMATION

Name of Insurance Co: _____________________________
Address of Insurance Co: _____________________________
Policy#: ___________ Group#: ___________ Insured Relationship to Patient: ___________
Insured Name: ___________________________ Insured DOB: ________ Insured SSN: ___________
Insured Mailing Address: _____________________________
City: _____________________________ State: ___________ Zip: ___________
Insured Phone#: ___________________________

WORK COMP/MOTOR VEHICLE INFORMATION

Is this visit related to a work injury? ☐ YES ☐ NO
If work related: Employer Name: _____________________________
Employer Phone Number: _____________________________
Is this visit related to a motor vehicle accident? ☐ YES ☐ NO

ASSIGNMENT OF BENEFITS

I hereby assign all medical and or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to: Bone & Joint Institute of South GA. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient Name: _____________________________
Patient/Guardian Signature: _____________________________
Date: _____________________________

JESUP
110 Professional Court, P.O. Box 1334, Jesup, Georgia 31545 | BAXLEY
1093 W. Parker Street, Suite A, Baxley, Georgia 31513
HINESVILLE
475 S. Main Street, Suite A, Hinesville, Georgia 31313 | WAYCROSS
1912 Memorial Drive, Suite D, Waycross, Georgia 31501
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August 28, 2017
PATIENT INFORMATION

Patient Name: ___________________________ Date of Birth: ___________________________

Weight: ____________ Height: ____________ Gender: ☐ MALE ☐ FEMALE

PLEASE ANSWER EACH QUESTION TO THE BEST OF YOUR ABILITY.

Who requested that you visit this office? Doctor (Name): ___________________________

Self Referral: ☐YES ☐NO

Did you bring X-Rays? ☐YES ☐NO

What is the main reason for your visit today? ___________________________

CHECK WHAT BODY PART IS INVOLVED AND INDICATE THE RIGHT (R) OR LEFT (L) SIDE AFFECTED:

☐ Neck ☐ Shoulder ☐ Elbow ☐ Hand ☐ Pelvis ☐ Knee ☐ Foot ☐ Leg

☐ Back ☐ Arm ☐ Wrist ☐ Finger ☐ Hip ☐ Ankle ☐ Toe ☐ Other

CHECK THE BOX BELOW WHICH BEST FITS HOW YOUR PROBLEM STARTED. ALSO PROVIDE ANY DETAILS

☐ NO INJURY Onset was: ☐ Gradual or ☐ Sudden

Why do you think it started? ___________________________

How long have you had this problem? ___________________________

☐ INJURY ☐ NOT AUTO OR WORK

☐ Accident or ☐ Sport If Accident: DATE: _____________ Where and How did it happen? ___________________________

If Sport: What Sport: ___________________________ School: ___________________________

☐ WORK INJURY ☐ INJURED ON THE JOB

☐ DATE: _____________ Where and How did it happen? ___________________________

☐ WORK RELATED ☐ BUT NO INJURY

☐ DATE: _____________ How did your job cause this problem? ___________________________

☐ AUTO ACCIDENT: Date: _____________ How was your car hit? ___________________________

CIRCLE THE SEVERITY OF YOUR PAIN 0 1 2 3 4 5 6 7 8 9 10 (0 - NO PAIN 10 - WORST PAIN EVER!)

Does your pain wake you from sleep? ☐ YES ☐ NO

Which applies to your problem? ☐ Pain ☐ Numbness ☐ Tingling

What makes your symptoms worse? ☐ Activity ☐ Exercise ☐ Work ☐ Other: ___________________________

What makes your symptoms feel better? ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Other: ___________________________

Are there associated symptoms? ☐ Cramping ☐ Numbness ☐ Tingling ☐ Weakness ☐ Mass

Have you received any previous treatment for this problem? ☐ YES ☐ NO

If yes, Please explain: (example: brace, medication, therapy, surgery, and injection)

How has this problem affected your daily life? ☐ Created problems at home ☐ Created problems at work

☐ Created problems at school ☐ Created interpersonal problems

Patient Signature: ___________________________ Date: ___________________________
INSTRUCTIONS: On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition.

PLEASE INDICATE ON THE ILLUSTRATIONS TO THE RIGHT WHERE YOU ARE EXPERIENCING AND PAIN AND/OR NUMBNESS

SHARP PAIN – PLEASE INDICATE BY USING “XXX”

DULL ACHY PAIN - PLEASE INDICATE BY USING “###”

NUMBNESS - PLEASE INDICATE BY USING “///”

I CERTIFY THAT THE INFORMATION GIVEN ON THIS PAIN DIAGRAM IS TRUE AND COMPLETE.

Patient Name: ____________________________

Patient/Guardian Signature: ____________________________

Relationship to Patient: ____________________________

Date: ____________________________
MEDICATION LIST

Please list all prescription, over the counter, vitamins and dietary supplements that you are currently taking or recently completed.

Patient Name: ___________________________ Date of Birth: ________________

Drug Allergies: ____________________________

Preferred Pharmacy: ___________________________ City: ___________________________

☐ I am not currently taking any medications.

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>STRENGTH (MG, UNITS, DROPS)</th>
<th>HOW OFTEN (HOW MANY PER DAY)</th>
<th>REASON</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBUPROFEN</td>
<td>800 MG</td>
<td>1X/DAY</td>
<td>PAIN - AS NEEDED</td>
</tr>
<tr>
<td>NOVOLOG</td>
<td>10 UNITS</td>
<td>3X/DAY</td>
<td>DIABETES</td>
</tr>
</tbody>
</table>
AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient’s consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give consent to release this information to the family members indicated below. This consent form will not allow Bone & Joint Institute of South Georgia to release any other information to these family members.

YOU HAVE THE RIGHT TO REVOKE THIS CONSENT IN WRITING.

I authorize Bone & Joint Institute of South Georgia to release my medical/billing information to the following individual(s):

Individual (1): ____________________________
Relationship to patient ____________________________

Individual (2): ____________________________
Relationship to patient ____________________________

Individual (3): ____________________________
Relationship to patient ____________________________

Patient Name: ____________________________
Patient Signature: ____________________________
Date: ____________________________
TEXT MESSAGE APPOINTMENT REMINDERS

The Bone & Joint Institute of South Georgia offers a text messaging system to current patients to receive appointment confirmations and other services and content deemed appropriate. Message and data rates may apply; please contact your wireless provider for specific information regarding your text messaging usage and charges.

Patient Name: __________________________________________________________

Date of Birth: _________________________________________________________

Address: ______________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

Please send text messages to mobile number: ______________________________

If I choose to no longer receive text message reminders, I will notify Bone & Joint Institute of South Georgia.

Patient Initials

Patient Name: __________________________________________________________

Patient Signature: ______________________________________________________

Date: __________________________________________________________________

August 28, 2017
Thank you for choosing Bone and Joint Institute of South Georgia as your health care provider. Everyone benefits when office and financial policy arrangements are understood. In order that we may have a definite understanding in regard to the payment for services, the following is our policy.

**Payment is due at the time service is provided. We accept cash, personal checks, cashier checks, money orders, Visa, Mastercard, Discover and American Express. Returned checks will be subject to a $35 additional fee.**

**Patients who carry health insurance understand that all services furnished are charged directly to the patient and that he or she is personally responsible for payment of all services regardless of insurance.** As a courtesy to you we will help you process all your insurance claims. We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company at the time we provide service to you. We must emphasize that this is only an estimate and all charges you incur are your responsibility regardless of your insurance coverage. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Health insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer and the insurance company. Our office is not a party to that contract. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. However, this office will not enter into a dispute with your insurance company over any claim. Once insurance has paid their share, a statement will be sent to you for any remaining balance and will be due upon receipt. If your insurance company has not made payment within 60 days, the unpaid balance becomes your responsibility and is subject to finance charges and the collections process.

**Divorced Couples with Dependent Children:** It is the policy of this office to bill the parent that brings the children in for their care. Please make arrangements for payment from an ex-spouse before services are rendered.

**All Patients** must provide an **ID Card & Insurance Card** (if applicable) to be copied at the time of the appointment. We also require home, work and cell phone numbers, as well as a contact number to use in case of emergency.

**Cancellation & Late Policy:** Your appointment time is reserved for you. If you are late for your appointment, we may not be able to accommodate you. If you think that you will be late, please call as soon as possible so that we may advise you if your late arrival can be accommodated, or if we will need to reschedule you. We maintain a very strict schedule and must insist that appointment times be respected. For cancellation, we require 24 hours advanced notice. **Three missed appointments will result in dismissal as a patient.**

**CONSENT: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY BENEFITS DIRECTLY TO BONE AND JOINT INSTITUTE OF SOUTH GEORGIA.**

Patient Name: ____________________________

Patient/Guardian Signature: ____________________________

Date: ____________________________