



Welcome to our practice!

We are pleased that you have chosen to trust Orthopaedic Center of the Carolinas with your health care, and we look forward to meeting you.

Enclosed you will find our New Patient Packet which includes information about our practice and all the forms you need to complete in order for us to give you the best care possible. Please bring the completed forms with you for your appointment. We ask that you arrive 10-15 minutes before your scheduled time so that we can complete the registration process. Finally, please be sure to bring your driver's license (or picture ID), current insurance cards, medications, and any applicable films or x-rays.

Please feel free to contact our office at (864) 850-1968 should you have any questions or need additional information.

Sincerely,

William L. DeVault, MD

PATIENT INFORMATION

Who may we thank for referring you to our practice? _____

Date of Injury or Onset of problem: _____

Name:(First) _____ (MI): _____ (Last): _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Marital Status: _____

Date of Birth: ____ / ____ / ____ Social Security #: _____ Age: _____ Sex: _____

Employer: _____ Business Phone: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Parent or Legal Guardian Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Date of Birth: ____ / ____ / ____ Social Security # _____

Please list the name of a person to contact in case of emergency, other than a spouse or parent:

Name:(First) _____ (MI) _____ (Last) _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Relationship _____

PRIMARY INSURANCE

Ins. Co. Name: _____ Employer _____

Insured's Name _____ DOB ____ / ____ / ____ Social Security # _____

Group # _____ ID # _____

Relationship to Insured: _____

SECONDARY INSURANCE

Ins. Co. Name: _____ Employer _____

Insured's Name _____ DOB ____ / ____ / ____ Social Security # _____

Group # _____ ID # _____

Relationship to Insured: _____

MEDICAL HISTORY

Family Physician: _____ Phone: _____

Describe the condition that brought you in and indicate the date of injury (or onset of problem):

Have you had previous care? Y N If yes, Dr: _____ Date: _____

MEDICAL

Please check any of the following if they pertain to you:

Diabetes _____	Heart Attack _____	Seizures _____	Scar Former _____
High Blood Pressure _____	Angina/Chest Pain _____	Phlebitis _____	Thyroid Disorder _____
Mitral Valve Prolapse _____	Angioplasty _____	Hepatitis _____	Kidney Disorder _____
Bleeding Disorder _____	Stroke/TIA's _____	Ulcers _____	Asthma _____
Circulation Disorder _____	Anemia _____	Hiatal Hernia _____	Cirrhosis _____

ALLERGIES

Penicillin _____	Aspirin _____	Codeine _____	Other: _____
Novocain _____	Iodine _____	Tape _____	

MEDICATIONS

Please include Aspirin, Tylenol, Vitamins, and Birth Control Pills

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

PREVIOUS SURGERIES AND HOSPITALIZATIONS

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

FAMILY HISTORY

Diabetes _____	High Blood Pressure _____	Bleeding Tendencies _____
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SOCIAL HISTORY

Smoking _____	Alcohol _____	Recreational Drugs _____
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REVIEW OF SYSTEMS

Please circle a response for each item below.

CONSTITUTIONAL SYMPTOMS

Good general health lately?	No	Yes
Recent weight changes?	No	Yes
Fever?	No	Yes
Fatigue?	No	Yes

EYES

Eye disease or injury?	No	Yes
Wear glasses/contact lenses?	No	Yes
Blurred vision or double vision?	No	Yes
Glaucoma?	No	Yes

EARS/NOSE/MOUTH/THROAT

Chronic sinus problem or rhinitis?	No	Yes
Nose bleeds?	No	Yes
Sore throat or voice change?	No	Yes

CARDIOVASCULAR

Heart trouble?	No	Yes
Chest pain or angina?	No	Yes
Palpitation?	No	Yes
Shortness of breath while sitting or lying flat?	No	Yes
Swelling of feet, ankles or hands?	No	Yes

RESPIRATORY

Chronic or frequent coughs?	No	Yes
Spitting up blood?	No	Yes
Shortness of breath?	No	Yes
Asthma or wheezing?	No	Yes

GASTROINTESTINAL

Loss of appetite?	No	Yes
Nausea or vomiting?	No	Yes
Frequent diarrhea?	No	Yes
Constipation?	No	Yes
Rectal bleeding/Blood in stool?	No	Yes
Abdominal pain or heartburn?	No	Yes
Peptic ulcer (stomach or duodenal)?	No	Yes

MUSCULOSKELETAL

Joint Pain?	No	Yes
Joint Stiffness or Swelling?	No	Yes
Muscle pain or cramps?	No	Yes
Back pain?	No	Yes
Cold extremities?	No	Yes
Difficulty in walking?	No	Yes

INTEGUMENTARY (skin, breast)

Rash or itching?	No	Yes
Change in skin color?	No	Yes
Varicose veins?	No	Yes

NEUROLOGICAL

Numbness or tingling?	No	Yes
Paralysis?	No	Yes
Stroke?	No	Yes
Head injury?	No	Yes
Convulsions or seizures?	No	Yes

PSYCHIATRIC

Memory loss or confusion?	No	Yes
Nervousness?	No	Yes
Depression?	No	Yes
Insomnia?	No	Yes

ENDOCRINE

Thyroid disease?	No	Yes
Diabetes?	No	Yes
Change in hat or glove size?	No	Yes

HEMATOLOGICAL/LYMPHATIC

Slow to heal after cuts?	No	Yes
Bleeding or bruising tendency?	No	Yes
Anemia?	No	Yes
Phlebitis?	No	Yes
Past transfusion?	No	Yes
Enlarged glands?	No	Yes

Notes: (for Physician use):

OFFICE POLICIES

HOURS

Our office hours are Monday through Friday, 8:00 a.m. to 4:45 p.m. We are closed daily from noon to 1:30 p.m. Please call during normal office hours for appointments or billing questions. For urgent matters, there is a physician on call 24 hours a day.

APPOINTMENTS

Because we strive to keep our waiting times to a minimum, we request patients arrive promptly for their scheduled appointments. If you are more than 15 minutes late for your appointment, we will offer to reschedule your appointment or you will be worked in as time permits.

RECORDS, FILMS, XRAY

Please bring any records, films, or x-rays pertinent to your care with you to your appointment. The physician will be unable to make correct treatment decisions if these items are not present at the visit. If you are unable to obtain these items, please contact our office so we can work with you to get them, or reschedule your visit if necessary.

INSURANCE AND IDENTIFICATION

We require proof of current insurance and a picture ID at each visit. If you are unable to provide proper documentation, we will need to reschedule your appointment.

Our office currently does not accept Self Pay or Medicaid. Please let us know if you fall into any of these groups so that we may either make payment arrangements prior to care, or refer you to another orthopedist.

COPAYS

As required by our legal contract with the insurance companies, we are **required to collect all co-pays at the time of your service**. It is our practice policy to collect these at the front window upon check in before services are rendered. If you are unable to pay your co pay, we will need to reschedule your appointment.

PRESCRIPTIONS

Please ask for any prescription refills at the time of your visit. Prescription refill requests that are called in will be handled as time permits in the schedule. It could be as long as 24 to 48 hours before your refill can be approved and called in to your pharmacy. No prescription refill requests will be processed after noon on Fridays.

Please keep this page for your reference.

FINANCIAL POLICIES

Please initial each section, then sign at the bottom of the page.

REFERRALS

Orthopaedic Center of the Carolinas, PA participates with many insurance companies. It is **your** responsibility to check with your insurance company to see if they will pay for you to come here. If a referral is required, it is **your** responsibility to obtain this referral from your primary care physician.

COPAYS

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INSURANCE / BILLING

We currently file your insurance for you. For this process to go smoothly, it is essential for us to have **current and correct** insurance information as well as **current and correct** demographic information about you. Any services performed in our office that are not covered by your insurance will be billed to you. In addition, if your insurance company does not respond to our request for payment, you will receive an invoice in the mail for the balance due. The balance of that claim will be **your** responsibility to settle with us and your insurance company. **Any services performed in our office that are not covered by your insurance will be billed to you and full payment must be made within 90 days or your account will go to collections**. We will be happy to give you information to allow for prompt processing of your claim from your insurance company – we want to help you receive the benefit which you paid for with your premiums.

FORMS

If your medical condition requires any disability, insurance or physical forms to be filled out, please be aware that there is a \$15 charge per form, and it will take us approximately 48 hours to complete. Because insurance does not pay for this service, it will be your responsibility to pay us at the time the forms are dropped off.

CHILDREN OF DIVORCED AND SEPARATED PARENTS

The individual who brings the child to the office is responsible for payment of fees charged for that child's care. If another agrees to payment responsibility, that person must provide an acknowledgement in writing of their desire to pay for care. It is the responsibility of the person bringing the child to the office to obtain a written agreement and to inform the other person of care being provided.

Patient's or Legal Guardian's Signature

Date

**AUTHORIZATION FOR TREATMENT /
RELEASE OF INFORMATION /
FINANCIAL AGREEMENT**

I, the undersigned, knowing the patient (minor) and/or self, is suffering from a condition requiring health care, diagnosis and/or medical treatment hereby voluntarily agree to such diagnostic procedures and health care and assignees. I authorize the release of medical information to my referring doctor, health agency, government agency, insurance company or worker's compensation. I request that payment to insurance benefits made on my behalf be paid directly to Orthopaedic Center of the Carolinas, PA. I assume full financial responsibility for all debts incurred in any treatment and follow up care received. I understand that payment is due at the time services are rendered, and I further understand that I am financially responsible for all charges whether or not paid by the insurance carrier. It is the patient's responsibility to obtain authorization from their Primary Care Physician or insurance company (if required by your insurance company) prior to services being rendered.

Patient's or Legal Guardian's Signature

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we will gladly make available to you a full copy of our Patient Privacy Practices regarding your Personal Health Information (PHI) upon request.

I understand that the purpose of this notice is to inform me of my rights pertaining to my Protected Health Information (PHI) and also the ways in which the Orthopaedic Center of the Carolinas, PA may use or disclose my PHI.

Patient (or Legal Representative) Signature

Date

I, _____ give Orthopaedic Center of the Carolinas, PA permission to discuss my medical records/insurance issues/appointment issues with:

Name (Please Print)

Relationship to patient

Name (Please Print)

Relationship to patient

I give Orthopaedic Center of the Carolinas, PA permission to contact me in the following ways: (please check all that apply):

_____ Home Phone _____ Work Phone _____ Cell Phone
_____ E-mail _____ Mail

I also give Orthopaedic Center of the Carolinas, PA permission to leave a message or an email with the following information: (please check all that apply):

_____ Appointment Information _____ Test Results
_____ Prescription Information _____ Returning Correspondence

Patient Name: _____ Date: _____

Patient (or Legal Representative) Signature: _____

Witness Signature: _____ Date: _____

ACCIDENT/INJURY QUESTIONNAIRE

SECTION ONE

Date of Injury/Accident: _____ Referred by: _____

Is the reason for your visit due to an injury caused by an accident: _____ Yes _____ No

If no, please briefly explain the nature of your problem: _____

Was the injury/ accident due to: _____ Auto/Motorcycle _____ Work _____ School _____ Home _____ Other

Briefly describe the injury/accident and give details on how it occurred:

SECTION TWO

If you checked "Auto/Motorcycle" or "other" in Section One, please answer the following:

Did another person cause this accident? _____ Yes _____ No

If yes, name and address of person causing the injury:

Insurance Company of person causing injury:

Insurance Company Address and Phone:

If auto or motorcycle related was the patient wearing a seatbelt? __ Yes __ No

A Helmet? __ Yes __ No

If auto or motorcycle related was the patient the driver _____ or passenger _____?

Auto Insurance Company of Patient: _____ Policy/Claim #: _____

Address and Phone #: _____

Adjuster's Name and Contact Information: _____

SECTION THREE

If you checked "Work Related" please answer the following:

Name and address of patient's employer at the time of injury?

Have you filed a Worker's Compensation Claim? _____ Yes _____ No

If yes, name of Worker's Compensation Carrier: _____

Policy/Claim #: _____ Adjuster's Name: _____

Address and Phone #: _____

Has the employer of the workers' compensation carrier accepted or denied liability?

___ Accepted ___ Declined

Name, address and telephone number of your attorney (if applicable):

To the best of my knowledge the statements above are accurate and complete. Unanswered questions indicate that they do not apply. My signature authorized _____ Insurance to receive any and all information concerning claims filed by me or on my behalf to another insurance carrier.

Signature: _____ Date: _____

Printed name: _____

Witness Signature: _____ Date: _____

Printed name: _____