ALLEN
Spine And Sports Medicine

1721 Allen's Lane, Suite 101
Wilmington, NC 28403

509 Olde Waterford Way, Suite 305
Leland, NC 28451

910-515-1506

Full Name: _____
Last First Middle Maiden/Suffix

Address: _____
Street Apt/Condo # City State Zip

Date of Birth: _____ **Gender: M F** *Circle one* **SS#:** _____/_____/_____

Home Phone: _____**Mobile:**_____**Work:** _____

Employer: _____**How long**: ____yrs___months **Job Description:** _____

Emergency Contact: _____
Name Phone Relationship to patient

Insurance Information: Y N *Circle one if No, skip to next section*

Insured's Full Name: _____

Insured's Address: _____

_____

Insured's DOB: _____

Insured's SS#: _____/_____/_____

Insured's Gender: M F

Insured's Relationship to Patient: _____

Insurance Company: _____

Group #: _____

ID#: _____

Policy #: _____

Insured's Employer: _____

Responsible Party Information:

Full Name: _____
Last First Middle initial Relationship to patient

Address: _____
Street Apt/Condo # City State Zip

Home Phone: _____**Mobile:**_____**Work:** _____

Reason for Today's Appointment:

_____

_____

_____

Referring Physician: _____**Office Phone:** _____

Primary Care Physician: _____
name *address* *phone*

Any current medical issues? _____

_____

Did you bring any medical/other records with you? **Y** **N** *If yes, please give to receptionist after signing this form for use in treatment.*

History

Medical:

Allergies to any Medications? _____

_____

Previous Surgeries: _____
list reason & date

_____

_____

_____

Current Medications: **Dosage:**

_____

_____

_____

_____

_____

Family:

Circle if any history in immediate family

Arthritis, gout _____

Cancer _____

Diabetes _____

Heart Disease, Stroke _____

Kidney Disease _____

High Blood Pressure _____

Other _____

Lifestyle Habits:

Substance Use:

Caffeine _____
amount use/how often

Tobacco _____
amount used/how often

Alcohol _____
amount used/how often

Other: _____
amount used/how often

Exercise: *circle one*

Daily Weekly Monthly

Duration: ____hrs ____ mins

Symptoms: *Circle any within the last 12 months.*

Fever	Chest Pain	Frequency/urgency/ pain w urination	Paralysis
Weight loss	Irregular Heartbeat		Convulsions
Chills	Palpitations	Prostate Disease	Insomnia
Fainting	Shortness of Breath	Blood in Urine	Depression
Blurred Vision	Asthma/Wheezing	Weakness	Anxiety
Double Vision	Spitting up Blood	Pain in Joints	Memory Loss
Floaters	Persistent Cough	Loss of Motion	Swelling of Ankles
Loss of Hearing	Poor Appetite	Rash	Anemia
Ringing in Ears	Indigestion	Bruises easily	Phlebitis
Trouble Swallowing	Diarrhea	Change in moles	Deep Vein Thrombosis
Hoarseness	Constipation	Itching	
Bleeding Gums	Nausea	Dizziness	
Sinus Problems	Vomiting	Tremors	

INFORMED CONSENT TO MEDICAL TREATMENT

1. I voluntarily authorize the performance upon _____ of procedures deemed medically necessary for treatment of said condition by Dr. Joanne B. Allen or any designee of Dr. Allen while at Allen Spine and Sports Medicine, PC.

2. I understand the nature and purpose of the operation and/or procedures, the usual and most frequent risks of the proposed procedure, including the risk that such treatment may not accomplish the desired objectives and the possible or likely benefits of the procedure and all feasible alternate methods of treatment.

3. I am aware that, in addition to the specific risks of any procedure, there are other possible risks, which are inherent in the performance of any procedure. I am also aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me about the results of the procedure.

4. I authorize the administration of such topical numbing agents as may be necessary or advisable by Dr. Allen to perform the procedure.

5. I have had sufficient opportunity to discuss my condition and treatment with Dr. Allen and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base an informed consent to the proposed treatment.

6. I understand that any of the above that I do not consent to will be lined through, dated and initialed.

By signing here, I indicated that I have understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document.

_____ _____
Patient or Legal Representative/Guardian *Date/Time Signed*

_____
Relationship to Patient

Authorization to Release Confidential Medical Information

I authorize the release of medical information to my primary care or referring physician and as necessary to process insurance claims, including claims for disability benefits, insurance applications and prescriptions. I authorize
transmission of medical information by fax.
Patient Name*(print)*_____Patient SS# _____/_____/_____
Patient or Responsible Party Signature _____Date _____/_____/_____

RX REFILLS

I agree that Allen Spine and Sports Medicine, PC(ASSM) may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.
Patient or Responsible Party Signature _____ Date _____/_____/_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed a copy of the Notice of Privacy Practices for Allen Spine and Sports Medicine, PC.
Patient or Responsible Party Signature _____ Date _____/_____/_____

ACCEPTANCE OF FINANCIAL RESPONSIBILITY

X_____ *(initial)* I acknowledge full financial responsibility for services rendered by Allen Spine and Sports Medicine, PC, regardless of insurance coverage and whether or not there was an accident with another party at fault

INSURANCE PATIENTS

X_____ *(initial)* Allen Spine and Sports Medicine, PC will file your insurance. I authorize my health insurance company to utilize the medical information as reasonably necessary for the proper

administration of the health plan. I hereby assign ASSM any payments of medical benefits for services rendered to myself or dependents.

Co-payments: Allen Spine and Sports Medicine is required by your insurance to collect your co-payment. If you do not have your co-payment your appointment could be rescheduled. I have read and understand that I am responsible for paying the annual deductible, co-payment, coinsurance and any charges for non-covered services as determined by my insurance.

SELF-PAY PAY PATIENTS

X_____ *(initial)* Patients will need to make a $175 deposit prior to seeing the physician, and self- pay patients with a back condition will need to make a $250 deposit prior to seeing the physician.

OUTSTANDING BALANCES

X_____ *(initial)* Any patients having an outstanding balance with a collection agency will not be able to make an appointment until the balance is paid in full. Any third party costs associated with collecting past due accounts will be added to the patient's account.

_____

Patient or Legal Guardian/Representative

_____

Date Signed

_____

Print Patient Name