Carolina
Sports Medicine & Orthopaedic Specialists

1717 Shipyard Blvd., Suite 350 • Wilmington, NC 28403
Phone (910) 799-0110

Orthopaedic Universal Data Form Date________________

Patient's Name__________________________
Last First MI

Male__ Female__ Age___ **Birthdate:**________________

Address______________________________

City, State, Zip__________________________

Home Phone (____)_______________________

Patient's Social Security #________________

Work Phone (____)_______________________

Fax Number (____)_______________________

Physician you are seeing today: Dr. Esposito ______

Dr. Messina ______ Dr. Lippe ______

Referred by:____________________________
(If another Doctor, who?, Yellow Pages, Friend, etc)

Family/Primary Care Physician_____________________

Emergency Contact:

Name_______________________________

Phone_______________Relation:_____________

Are you employed? Yes___ No___ How long?______

Occupation________________ Full Time__ Part Time__

Employer_______________________________

Employer Address_________________________

City, State, Zip__________________________

Employer Phone #_________________________

Patient's Driver's License_________________
Number State

Married___ Single___ Divorced___ Separated__ Widowed__

Spouse's Name___________________________

Spouse's Employer________________________

Are you a student? Yes___ No___
If yes, Full time__Part time__

Usual Pharmacy:__________________________

Primary Insurance/Worker's Comp

Carrier Name____________________________

Address________________________________
(Where claim is to be mailed)

Carrier Phone #__________________________

Policy #/Case #__________________________

Group #_________________________________

Policy Holder's Name_____________________

Policy Holder's Birth Date_________________

Pt's relationship to Policy Holder:

Self_______ Dependent_______ Spouse_______

Child________ Other___________

Secondary Insurance

Carrier Name____________________________

Address________________________________
(Where claim is to be mailed)

Carrier Phone #__________________________

Policy #/Case #__________________________

Group #_________________________________

Policy Holder's Name_____________________

Policy Holder's Birth Date_________________

Pt's relationship to Policy Holder:

Self_______ Dependent_______ Spouse_______

Child________ Other___________

Please give your insurance cards to the receptionist so that a copy can be made for our records.

Responsible Party (RP) Information:

RP Name________________________________

Address________________________________

City, State, Zip__________________________

Home Phone (____)_______________________

SS #_________________ Birth Date:___________

RP Occupation___________________________

Employer_______________________________

Address________________________________

City, State, Zip__________________________

Work Phone (____)_______________________

Patient Name ______________________________

Current Problem:

Describe your current problem ____

____

____

When did this problem begin? ________________________ If accident, give date of accident: _____/______/________

Were you injured on the job? _____Yes _____No If yes, describe how the injury occurred: ____________________

____

____

Were you injured in an auto accident? _____Yes _____No

Were X-Rays taken? ___Yes ___No If Yes, Where were they taken? ______________________________________

Did you bring these X-Rays today? ___Yes ___No Were you seen in the E.R. by our Doctor? ____Yes ____No

Do you have an attorney? ___Yes ___No If Yes, Name ____

Have you previously been treated by a physician in this practice? ___Yes ___No If Yes, approx. when? ____________

Signature Release for Treatment (If Minor, Guardian signature) ______________________________________ Date __________

Insurance Assignment:

I, the undersigned, have insurance coverage and assign directly to Carolina Sports Medicine all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission whether manual or electronic.

______________________________________ ____________________

Signature of Insured/Guardian Date

Medicare Authorization:

I request that payment of authorized Medicare benefits be made on my behalf to Carolina Sports Medicine for any services furnished me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases,, Carolina Sports Medicine agrees to accept the charge determination of the Medicare carrier as the full charge, and I am responsible for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________________________ ____________________

Beneficiary Signature Date

Medical History

CF Reg 452-8121
Fax this side

Patient Name________________________________ **Today's Date**______________ **Age**_____ **BirthDate**______

Please circle "Y" below if you have problems with these medical conditions and "N" if you do not have problems:

Skin/Breast:
- Y N Rash or problems with itching
- Y N Varicose veins
- Y N Breast lump

Eyes/Ears/Nose/Mouth/Throat:
- Y N Blurred or double vision
- Y N Eyes diseases
- Y N Hearing loss or ringing
- Y N Earaches or ear drainage
- Y N Sinus problems or "runny nose"
- Y N Nose bleeds
- Y N Loose or chipped teeth
- Y N Dentures or bridge
- Y N Problems opening mouth wide
- Y N Sore throat or change in your voice
- Y N Swollen glands in your neck

Lungs:
- Y N Breathing problems or asthma
- Y N Breathing problems during sleep
- Y N Tuberculosis or emphysema

Cardiac (Heart and Blood Vessels):
- Y N Chest pain or angina pectoris
- Y N Heart disease or heart trouble
- Y N Recent chest pressure or tightness
- Y N Shortness of breath on exertion
- Y N Shortness of breath when lying flat
- Y N High blood pressure
- Y N Recent heart palpitations
- Y N Swelling of the feet, ankles, or hands
- Y N Bleeding disorder
- Y N Take a blood thinner, e.g., Coumadin

Endocrine:
- Y N Diabetes or high blood sugar
- Y N Do you take insulin?

Intestines and Kidneys:
- Y N Frequent, burning or painful urination
- Y N Blood in your urine
- Y N Urinary incontinence or dribbling
- Y N Kidney stones
- Y N Kidney or liver disease
- Y N Males: Testicle pain
- Y N Males: Prostate problems
- Females: Number of pregnancies___
- Y N Change in bowel movements
- Y N Nausea or vomiting
- Y N Frequent diarrhea
- Y N Rectal bleeding or blood in your bowel movements
- Y N Frequent abdominal pain or heartburn

Musculoskeletal:
- Y N Arthritis
- Y N Osteoporosis
- Y N Major Fractures

Neurological (Nerves):
- Y N Frequent, recurring headaches
- Y N Dizziness
- Y N Numbness or tingling sensations
- Y N Convulsions , seizures or tremors
- Y N Any kind of head injury
- Y N Stroke or "mini stroke"

Psychiatric:
- Y N Memory loss or confusion
- Y N Feelings of nervousness
- Y N Feelings of depression
- Y N Trouble sleeping

Social:
- Y N Drink alcoholic beverages
  If yes, how much?____________
- Y N Use any recreational drugs
- Y N Smoke
  If yes, how much?____________

Anesthesia History:
- Y N Any anesthesia problems other than nausea and vomiting?
- Y N Difficulty opening your mouth?
- Y N Family history of malignant hypertension?
- Y N History of prolonged weakness after anesthesia?

Medications	Dose	How Often?

Family History: **(Circle Y for all that apply)**

Y N Diabetes	Y N Cancer	Y N Hypertension
Y N Bleeding Tendency	Y N Sickle Cell	Y N Heart Disease

Other Medical Problems:____

Past Surgeries	What Facility?	Problems?
		Y N
		Y N
		Y N

Recent Procedures/Tests	When	Where?

Height_____ **Weight**_____ **Allergies**________________________________

I certify that this information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Primary Care Physician________________

Physician Reviewed________________

Date:________________

____

Signature **Date**

Patient Name______________________________

Review of Health History:

	Yes	No	Unknown
Have you been in good general health lately?	☐	☐	☐
Have you experienced a recent unplanned weight loss?	☐	☐	☐
Have you been running a fever?	☐	☐	☐
Have you been feeling fatigued?	☐	☐	☐

List any other information regarding medical problems:______________________________

Family History of Illnesses:

Father ______________________________

Mother ______________________________

Brothers/Sisters ______________________________