Primary Complaint: ____

When did symptoms begin? ____

Did you injure yourself at work? ☐Yes ☐No Date of injury: ______________________

Are you currently working? ______ ☐ Full-Duty ☐ Light Duty

How did the injury occur? ____

Have you had previous back or neck problems? ☐Yes ☐No

If yes, describe: ____

What makes it worse? ____

What makes it better? ____

Does coughing or sneezing make it worse? ☐Yes ☐No

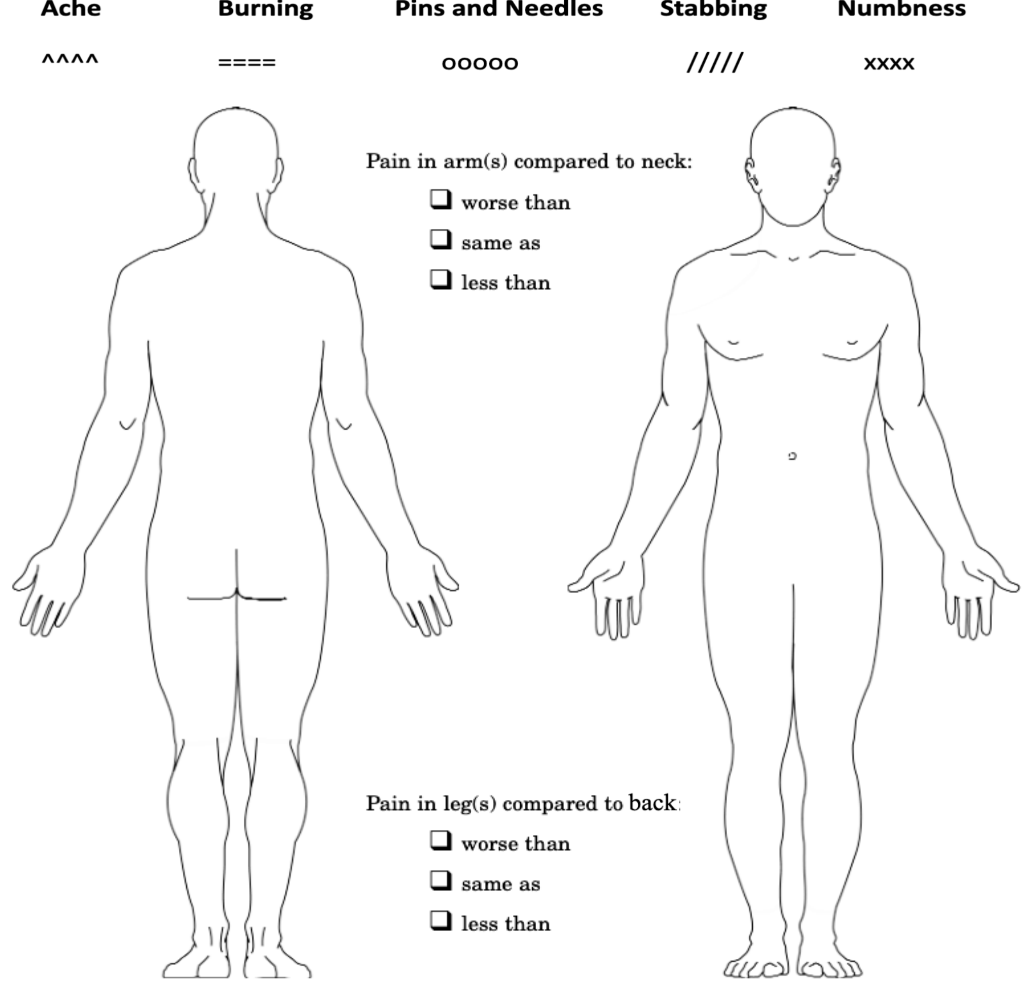
Do you have any associated symptoms? (Check all that apply)

☐ Numbness ☐ Tingling ☐ Weakness ☐ Balance Problems

☐ Fatigue ☐ Dizziness ☐ Headache ☐ Bowel or Bladder Incontinence

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

Ache	Burning	Pins and Needles	Stabbing	Numbness
^^^^	====	ooooo	/////	xxxx



Have you ever had an epidural block or steroid injection for pain? ☐Yes ☐No

For which part of the body? ________________________ How many blocks received? _________________

Who performed blocks? ____

Date(s) blocks received: ____

How long did you get relief from the blocks? ____

Have you ever seen a Chiropractor? ☐Yes ☐No If yes, name of provider and dates seen:

____

Have you undergone any physical therapy for this issue? ☐Yes ☐No If yes, name of provider and dates seen:

____

Have you had any recent imaging (X-Ray, MRI, CT, etc.)?

Facility: ____ Phone #: _________________________________

Type of Imaging: ____ Date: __________________________

Facility: ____ Phone #: _________________________________

Type of Imaging: ____ Date: __________________________

Please list any previous neck or back surgery and date performed: ___________________________________

____

Please list all past and present medical problems:

____

____

____

Please list any major surgeries with dates:

____

____

PLEASE LIST ANY MAJOR COMPLICATION AFTER ANY MAJOR SURGERY PERFORMED IN THE PAST. (i.e. infections, blood clots, lung disorders, nerve damage, bleeding disorders, anesthesia, sexual dysfunctions.)

____

Do any immediate family members have any of the following medical conditions?

Relationship to you

☐ Diabetes ____

☐ Hypertension ____

☐ Heart Disease ____

☐ Stroke ____

☐ Cancer (Specify type) ____

☐ Aneurysm ____

☐ Other (Please specify) ____

Smoking Status: ☐Never ☐Former ☐Current, how much? ____________________

Do you drink alcohol? ____ How much? _____________ Any illicit drugs? ____ How much?______________

Please list any drug allergies and reaction caused: ☐ Check if no known drug allergies

____

____

Please list all current prescription and over-the-counter medications: ☐ I do not take any medications

Medication name	Dosage	Frequency

Signature of Patient ____ Date: ____________________

Dr. Gregg K. Carr, M.D.
Dr. Tuan Nguyen, M.D. 516 Brookwood Blvd Birmingham, AL 35209 P:

Dr. Gregg K. Carr, M.D.
516 Brookwood Blvd
Birmingham, AL 35209
P: 205-397-2663
F: 205-278-0049

HIPAA AUTHORIZATION FORM

Patient Name: ______________________ **Date of Birth:** ______________________

Patient Address: ______________________ **SSN:** ______________________

______________________ **Email:** ______________________

I authorize Southern Orthopaedic Specialists, P.C. to discuss my medical information with the following people:

None

Parents: ______________________

Spouse: ______________________

Mother (only): ______________________

Guardian: ______________________

Father (only): ______________________

Other: ______________________

relationship to patient: ______________________

I authorize Southern Orthopaedic Specialists, P.C. to contact me in the following manner(s) (check all that apply):

Home Telephone ______________________
- Okay to leave a message with detailed information
- Leave message with call back number only

Work Telephone ______________________
- Okay to leave a message with detailed information
- Leave message with call back number only

Written Communication
- Okay to mail to my home address
- Okay to mail to my work address
- Okay to fax to this number: ______________________

Email: ______________________

The HIPAA Privacy Act generally requires healthcare providers to take responsible steps to limit the disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses and disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record. Uses and disclosures of protected health information may be permitted without prior consent in an emergency.

You agree, in order for us to service our account or to collect any amounts you may owe, that we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

ACKNOWLEDGEMENTS:

I acknowledge that I have received a copy of the Notice of Privacy Practices for Southern Orthopaedic Specialists, P.C.

______________________ ______________________

Signature of Patient or Personal Representative **Date**

______________________ ______________________

Personal Representative's relationship to the Patient Signature of Witness

____

PRINT Personal Representative's Name

Southern Orthopaedic Specialists, P.C.

Consent Disclosures

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any and all collections agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE: You agree, in order for us to service your account or to collect monies you may owe, Southern Orthopaedic Specialists and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending you text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

NON-COVERED ROUTINE SERVICES POLICY: As your physician, I want to provide you with the best care possible. There may be certain routine services that I feel are necessary for the maintenance of good health that are not covered by your insurance contract, for example, I may order orthopaedic supplies (aircast, braces, heel cups, Ted hose, etc.). Let me assure you that I will order only those items that I feel are necessary for your treatment and care.
If you have any questions regarding any of our policies please speak to someone in the office and we will be happy to assist you.

____ ________________________
Patient/Responsible Party Date

Date of Visit

PATIENT REGISTRATION FORM – PLEASE PRINT

Primary Care Physician and Phone Number:

PATIENT INFORMATION

Last Name	Suffix (Jr, etc.)	First Name	M.I.	Age

Street Address	Zip Code	City	State

Soc. Sec. No.	Home Phone	Work Phone	Cell Phone	Sex: M F	Marital Status: S M W D	D.O.B.

Patient's Employer	Work Address	Employer's Phone

RESPONSIBLE PARTY INFORMATION

Relationship to Patient	Name	Social Security No.	Driver's License No.

Street Address	Zip Code	City	State

Home Phone	Work Phone	Cell Phone	Name of Employer

Employer's Street Address	Zip Code	City	State

INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Insurance Company		
Policy No.	Group No.	Effective Date
Relationship to Patient	Name of Insured	
Date of Birth	Insured's Employer	Copay $

SECONDARY INSURANCE

Name of Insurance Company		
Policy No.	Group No.	Effective Date
Relationship to Patient	Name of Insured	
Date of Birth	Insured's Employer	Copay $

INJURY INFORMATION

Job Related? ☐ Yes ☐ No	Date of Injury	Date Last Worked	Employer at Time of Injury

Workmans' Compensation Carrier	Where were you injured?
How did your injury occur?	Employer rep. who authorized treatment

IN CASE OF EMERGENCY NOTIFY (OTHER THAN RESPONSIBLE PARTY)

Person to contact	Relationship	Phone Number

Street Address	City	State	Zip

AUTHORIZATION AND RELEASE

I hereby authorize SOUTHERN ORTHOPAEDIC SPECIALISTS, P.C. (SOS) to release for insurance purposes any information acquired in the course of my examination or treatment. I authorize payment from my insurance company to be made directly to SOS for any treatment I receive while under their care. I will be responsible for any charges not paid by my insurance company.

I understand that I am responsible for payment of my account, and I agree to pay all costs of collection and interest charges, including a reasonable attorney's fee.

Patient's/Responsible Party's Signature ____________________ Date ____________