

**PATIENT INFORMATION**

Last Name	First Name	MI	Mr. / Mrs. / Ms.
SSN#	Date Of Birth	Age	Sex
Street Address	Apt #	City	State
Home Phone	Cell Phone	E-Mail Address	
Spouse's Name	Spouse's Phone		
Closest Relative (Not Living with Patient)	Relationship	Phone Number	
Ethnicity:	Race:	Primary Language:	

**GUARANTOR INFORMATION**

Guarantor Name	Guarantor Address	Phone
Employer & Phone:		

**INSURANCE INFORMATION**

<b>Primary</b> Insurance Co.		<b>Secondary</b> Insurance Co.	
Insured's Name		Insured's Name	
SS# of Policyholder	Date of Birth	SS# of Policyholder	Date of Birth
Relationship to Patient:		Relationship to Patient:	

**GENERAL**

Who Is your Primary Care Physician?	
Is this visit due to an injury (if so, Circle one)? <b>Auto Accident</b> or <b>Work related Injury</b> or <b>Other</b>	
Date of Injury / Accident:	Have you seen anyone for this condition? <b>Yes</b> or <b>No</b> If so Whom:
Marital Status: <b>S / M / D</b>	Do you live: <b>With Family / Alone / Assisted Living Facility</b>
Name & Location of your preferred pharmacy:	
Employer Name & Address:	
Occupation:	

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 Signature of Patient / Guarantor

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 Date

Patient Name:

Date:

**Medical Disorders (Choose yes or no for each disorder, list additional disorders in the space provided.)**

- |  |   |  |
|--|---|--|
| <input type="radio"/> Yes <input type="radio"/> No <b>AIDS/HIV</b>             | <input type="radio"/> Yes <input type="radio"/> No <b>Cancer Breast</b>   | <input type="radio"/> Yes <input type="radio"/> No <b>Gout</b>             |
| <input type="radio"/> Yes <input type="radio"/> No <b>Alcoholism</b>           | <input type="radio"/> Yes <input type="radio"/> No <b>Cancer Colon</b>    | <input type="radio"/> Yes <input type="radio"/> No <b>Heart Attack</b>     |
| <input type="radio"/> Yes <input type="radio"/> No <b>Alzheimer's</b>          | <input type="radio"/> Yes <input type="radio"/> No <b>Cancer Lung</b>     | <input type="radio"/> Yes <input type="radio"/> No <b>Hypertension</b>     |
| <input type="radio"/> Yes <input type="radio"/> No <b>Anemia</b>               | <input type="radio"/> Yes <input type="radio"/> No <b>Cancer Prostate</b> | <input type="radio"/> Yes <input type="radio"/> No <b>Hepatitis</b>        |
| <input type="radio"/> Yes <input type="radio"/> No <b>Rheumatoid Arthritis</b> | <input type="radio"/> Yes <input type="radio"/> No <b>COPD</b>            | <input type="radio"/> Yes <input type="radio"/> No <b>Kidney Disease</b>   |
| <input type="radio"/> Yes <input type="radio"/> No <b>Asthma</b>               | <input type="radio"/> Yes <input type="radio"/> No <b>Depression</b>      | <input type="radio"/> Yes <input type="radio"/> No <b>Osteoarthritis</b>   |
| <input type="radio"/> Yes <input type="radio"/> No <b>Blood Clot Leg</b>       | <input type="radio"/> Yes <input type="radio"/> No <b>Diabetes</b>        | <input type="radio"/> Yes <input type="radio"/> No <b>Seizures</b>         |
| <input type="radio"/> Yes <input type="radio"/> No <b>Blood Clot Lung</b>      | <input type="radio"/> Yes <input type="radio"/> No <b>Drug Abuse</b>      | <input type="radio"/> Yes <input type="radio"/> No <b>Ulcers, Bleeding</b> |

Please List Additional Disorders:

**Surgical History (Choose yes or no if you have had any of the following, list other surgeries in the space provided.)**

- |   |  |
|---|--|
| <input type="radio"/> Yes <input type="radio"/> No <b>Carpal Tunnel Left Wrist</b>  | <input type="radio"/> Yes <input type="radio"/> No <b>Carpal Tunnel Right Wrist</b>  |
| <input type="radio"/> Yes <input type="radio"/> No <b>Arthroscopy Left Elbow</b>    | <input type="radio"/> Yes <input type="radio"/> No <b>Arthroscopy Right Elbow</b>    |
| <input type="radio"/> Yes <input type="radio"/> No <b>Arthroscopy Left Shoulder</b> | <input type="radio"/> Yes <input type="radio"/> No <b>Arthroscopy Right Shoulder</b> |
| <input type="radio"/> Yes <input type="radio"/> No <b>Arthroscopy Left Ankle</b>    | <input type="radio"/> Yes <input type="radio"/> No <b>Arthroscopy Right Ankle</b>    |
| <input type="radio"/> Yes <input type="radio"/> No <b>Arthroscopy Left Knee</b>     | <input type="radio"/> Yes <input type="radio"/> No <b>Arthroscopy Right Knee</b>     |
| <input type="radio"/> Yes <input type="radio"/> No <b>Arthroscopy Left Hip</b>      | <input type="radio"/> Yes <input type="radio"/> No <b>Arthroscopy Right Hip</b>      |
| <input type="radio"/> Yes <input type="radio"/> No <b>Left Hip Replacement</b>      | <input type="radio"/> Yes <input type="radio"/> No <b>Right Hip Replacement</b>      |
| <input type="radio"/> Yes <input type="radio"/> No <b>Left Knee Replacement</b>     | <input type="radio"/> Yes <input type="radio"/> No <b>Right Knee Replacement</b>     |
| <input type="radio"/> Yes <input type="radio"/> No <b>Spinal Fusion</b>             | <input type="radio"/> Yes <input type="radio"/> No <b>Laminectomy</b>                |

Please List Other Surgeries:

Patient Name:

Date:

**Father Medical History** (Choose yes or no, list additional *relevant* history in the space provided.)

- |   |  |  |
|---|--|--|
| <input type="radio"/> Yes <input type="radio"/> No <b>AIDS/HIV</b>                | <input type="radio"/> Yes <input type="radio"/> No <b>Gout</b>                 | <input type="radio"/> Yes <input type="radio"/> No <b>Liver Disease</b>  |
| <input type="radio"/> Yes <input type="radio"/> No <b>Anemia</b>                  | <input type="radio"/> Yes <input type="radio"/> No <b>Heart Attack</b>         | <input type="radio"/> Yes <input type="radio"/> No <b>Muscle Disease</b> |
| <input type="radio"/> Yes <input type="radio"/> No <b>Blood Clots</b>             | <input type="radio"/> Yes <input type="radio"/> No <b>Hemophilia</b>           | <input type="radio"/> Yes <input type="radio"/> No <b>Osteoporosis</b>   |
| <input type="radio"/> Yes <input type="radio"/> No <b>Cancer</b>                  | <input type="radio"/> Yes <input type="radio"/> No <b>Hypertension</b>         | <input type="radio"/> Yes <input type="radio"/> No <b>Osteoarthritis</b> |
| <input type="radio"/> Yes <input type="radio"/> No <b>Diabetes</b>                | <input type="radio"/> Yes <input type="radio"/> No <b>Kidney Disease</b>       |  |
| <input type="radio"/> Yes <input type="radio"/> No <b>Coronary Artery Disease</b> | <input type="radio"/> Yes <input type="radio"/> No <b>Rheumatoid Arthritis</b> |  |

Additional History:

**Mother Medical History** (Choose yes or no, list additional *relevant* history in the space provided.)

- |   |  |  |
|---|--|--|
| <input type="radio"/> Yes <input type="radio"/> No <b>AIDS/HIV</b>                | <input type="radio"/> Yes <input type="radio"/> No <b>Gout</b>                 | <input type="radio"/> Yes <input type="radio"/> No <b>Liver Disease</b>  |
| <input type="radio"/> Yes <input type="radio"/> No <b>Anemia</b>                  | <input type="radio"/> Yes <input type="radio"/> No <b>Heart Attack</b>         | <input type="radio"/> Yes <input type="radio"/> No <b>Muscle Disease</b> |
| <input type="radio"/> Yes <input type="radio"/> No <b>Blood Clots</b>             | <input type="radio"/> Yes <input type="radio"/> No <b>Hemophilia</b>           | <input type="radio"/> Yes <input type="radio"/> No <b>Osteoporosis</b>   |
| <input type="radio"/> Yes <input type="radio"/> No <b>Cancer</b>                  | <input type="radio"/> Yes <input type="radio"/> No <b>Hypertension</b>         | <input type="radio"/> Yes <input type="radio"/> No <b>Osteoarthritis</b> |
| <input type="radio"/> Yes <input type="radio"/> No <b>Diabetes</b>                | <input type="radio"/> Yes <input type="radio"/> No <b>Kidney Disease</b>       |  |
| <input type="radio"/> Yes <input type="radio"/> No <b>Coronary Artery Disease</b> | <input type="radio"/> Yes <input type="radio"/> No <b>Rheumatoid Arthritis</b> |  |

Additional History:

**Sibling Medical History** (Choose yes or no, list additional *relevant* history in the space provided.)

- |   |  |  |
|---|--|--|
| <input type="radio"/> Yes <input type="radio"/> No <b>AIDS/HIV</b>                | <input type="radio"/> Yes <input type="radio"/> No <b>Gout</b>                 | <input type="radio"/> Yes <input type="radio"/> No <b>Liver Disease</b>  |
| <input type="radio"/> Yes <input type="radio"/> No <b>Anemia</b>                  | <input type="radio"/> Yes <input type="radio"/> No <b>Heart Attack</b>         | <input type="radio"/> Yes <input type="radio"/> No <b>Muscle Disease</b> |
| <input type="radio"/> Yes <input type="radio"/> No <b>Blood Clots</b>             | <input type="radio"/> Yes <input type="radio"/> No <b>Hemophilia</b>           | <input type="radio"/> Yes <input type="radio"/> No <b>Osteoporosis</b>   |
| <input type="radio"/> Yes <input type="radio"/> No <b>Cancer</b>                  | <input type="radio"/> Yes <input type="radio"/> No <b>Hypertension</b>         | <input type="radio"/> Yes <input type="radio"/> No <b>Osteoarthritis</b> |
| <input type="radio"/> Yes <input type="radio"/> No <b>Diabetes</b>                | <input type="radio"/> Yes <input type="radio"/> No <b>Kidney Disease</b>       |  |
| <input type="radio"/> Yes <input type="radio"/> No <b>Coronary Artery Disease</b> | <input type="radio"/> Yes <input type="radio"/> No <b>Rheumatoid Arthritis</b> |  |

Additional History:

Patient Name:

Date:

**Review of Systems (Choose yes or no for each of the following)**

Height: \_\_\_\_\_ Ft. \_\_\_\_\_ In.

Weight: \_\_\_\_\_ Lbs

**Constitutional**

- Yes  No **Weight Loss/Gain**
- Yes  No **Weakness**
- Yes  No **Fatigue**
- Yes  No **Fever**

**Cardiovascular**

- Yes  No **High Blood Pressure**
- Yes  No **Chest Pain**
- Yes  No **Rheumatic Fever**
- Yes  No **Palpitations**
- Yes  No **Has Pacemaker**

**Musculoskeletal**

- Yes  No **Joint Pain**
- Yes  No **Arthritis**
- Yes  No **Muscular Weakness**
- Yes  No **Stiffness**
- Yes  No **Muscular Pain**

**Eyes**

- Yes  No **Glasses / Contacts**
- Yes  No **Blurred Vision**
- Yes  No **Glaucoma**
- Yes  No **Cataracts**
- Yes  No **Excessive Tearing**

**Skin**

- Yes  No **Rashes**
- Yes  No **Sores**
- Yes  No **Lumps**
- Yes  No **Dryness**
- Yes  No **Itching**

**Blood or Lymph**

- Yes  No **Anemia**
- Yes  No **Easy Bruising**
- Yes  No **Easy Bleeding**
- Yes  No **Swollen Glands**

**Ear/Nose/Mouth/Throat**

- Yes  No **Ears Ringing**
- Yes  No **Earaches**
- Yes  No **Hearing Aid**
- Yes  No **Frequent Colds**
- Yes  No **Nasal Discharge**
- Yes  No **Hay Fever**
- Yes  No **Nosebleeds**
- Yes  No **Dentures**
- Yes  No **Bleeding Gums**
- Yes  No **Freq. Sore Throat**

**Neurological**

- Yes  No **Headache**
- Yes  No **Dizziness**
- Yes  No **Seizures**
- Yes  No **Loss of Sensation**
- Yes  No **Vertigo**

**Respiratory**

- Yes  No **Shortness of Breath**
- Yes  No **Cough**
- Yes  No **Wheezing**
- Yes  No **Asthma**
- Yes  No **Bronchitis**

**Gastrointestinal**

- Yes  No **Heart Burn**
- Yes  No **Rectal Bleeding**
- Yes  No **Abdominal Pain**
- Yes  No **Gallbladder Trouble**
- Yes  No **Hepatitis**

**Genitourinary**

- Yes  No **Blood in Urine**
- Yes  No **Urinary Infections**
- Yes  No **Kidney Stones**
- Yes  No **Burning Urination**
- Yes  No **Sexual Disease**

**Endocrine**

- Yes  No **Thyroid Trouble**
- Yes  No **Excessive Sweating**
- Yes  No **Excessive Thirst**

**Immunologic**

- Yes  No **Reactions to Drugs**
- Yes  No **Skin Rashes**
- Yes  No **Reactions to Food**

**Psychological**

- Yes  No **Nervousness**
- Yes  No **Depression**
- Yes  No **Mood Changes**

Patient Name:

Date:

**Social History (Choose yes or no for each of the following)**

**Substance Use**

**Do You...**

- Use Tobacco?     Yes  No  Former  
Use Alcohol?     Yes  No  Occasionally  
Use Caffeine?     Yes  No  
Use illicit Drugs?  Yes  No

**Current Medications** (List all medications / drugs you are currently using.)

**Known Allergies (Choose yes or no, list additional allergies in the space provided.)**

- |  |  |   |
|--|--|---|
| <input type="radio"/> Yes <input type="radio"/> No <b>Penicillin</b>   | <input type="radio"/> Yes <input type="radio"/> No <b>Amoxil</b>   | <input type="radio"/> Yes <input type="radio"/> No <b>Tegretol</b>  |
| <input type="radio"/> Yes <input type="radio"/> No <b>Codeines</b>     | <input type="radio"/> Yes <input type="radio"/> No <b>Keflex</b>   | <input type="radio"/> Yes <input type="radio"/> No <b>Bactrim</b>   |
| <input type="radio"/> Yes <input type="radio"/> No <b>Sulpha Drugs</b> | <input type="radio"/> Yes <input type="radio"/> No <b>Cefzil</b>   | <input type="radio"/> Yes <input type="radio"/> No <b>Pediazole</b> |
| <input type="radio"/> Yes <input type="radio"/> No <b>Iodine</b>       | <input type="radio"/> Yes <input type="radio"/> No <b>Ceftin</b>   | <input type="radio"/> Yes <input type="radio"/> No <b>Dilantin</b>  |
| <input type="radio"/> Yes <input type="radio"/> No <b>Ampicillin</b>   | <input type="radio"/> Yes <input type="radio"/> No <b>Suprax</b>   | <input type="radio"/> Yes <input type="radio"/> No <b>Novacaine</b> |
| <input type="radio"/> Yes <input type="radio"/> No <b>Vantin</b>       | <input type="radio"/> Yes <input type="radio"/> No <b>Septra</b>   | <input type="radio"/> Yes <input type="radio"/> No <b>Insulin</b>   |
| <input type="radio"/> Yes <input type="radio"/> No <b>Depakene</b>     | <input type="radio"/> Yes <input type="radio"/> No <b>Lamictal</b> |   |
| <input type="radio"/> Yes <input type="radio"/> No <b>Latex</b>        | <input type="radio"/> Yes <input type="radio"/> No <b>Metal</b>    |   |

**Miscellaneous (Choose the appropriate response.)**

**Hand Dominance:**  Left Handed  Right Handed      **(Females) Could you be Pregnant:**  Yes  No

**I attest that the information provided above is true and correct to the best of my knowledge.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**ASSIGNMENT OF BENEFITS**

I request that payment of my insurance(s) benefits be made to Forsyth Street Orthopaedic Surgery and Rehabilitation Centers on my behalf for any services furnished. I authorize any holder of medical information about me to release to the necessary insurance carrier, their intermediaries, or agents any information needed to determine benefits payable for related services. I release my power of attorney to Forsyth Street Orthopaedic Providers and their staff for collections/appeals process of claims on my behalf for all claims as deemed necessary.

I understand it is THE PATIENT'S RESPONSIBILITY to provide Forsyth Street Orthopaedic Providers with correct insurance information. If at any time during my care this information changes it is MY RESPONSIBILITY to notify Forsyth Street of those changes immediately. All claims denied due to inaccurate information provided by the patient or representative of the patient will be transferred to patient responsibility for payment of all billed charges.

**ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of [Forsyth Street Orthopaedic Surgery](#) Notice of Privacy Practices. By signing below I am “only” giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

If you would like to authorize additional family members, friends, or legal guardians, please notify our staff immediately.

By signing below you indicate acceptance to all of the above.

\_\_\_\_\_  
Patient Name (Type or Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient (Guarantor if applicable)

\_\_\_\_\_  
Guarantor relationship to patient

Frank B. Kelly, M.D.  
General orthopaedics

Charles H. Richardson, M.D.  
Spinal disorders and  
foot and ankle surgery

Gary L. Hattaway, M.D.  
Joint replacement,  
arthroscopic surgery,  
and spine surgery

Joseph E. Slappey, Jr., M.D.  
General orthopaedics,  
joint replacement and  
arthroscopic surgery

Timothy R. Stapleton, M.D.  
Joint replacement, shoulder  
surgery and sports medicine

Don C. Beringer, M.D.  
Joint replacement  
and shoulder surgery

Wood D. Pope, M.D.  
General orthopaedics, sports  
medicine, joint replacement,  
upper extremity, and foot  
and ankle surgery

Imaging Center  
478.743.3000

Rehab Center  
478.749.1612

Surgery Center  
478.749.1610



*The next generation of patient information*

## Permission to share my medical information from Forsyth Street Orthopaedics with my healthcare providers through the Central Georgia Health Exchange

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, **Forsyth Street Orthopaedics** would like your permission to share your information through the *Central Georgia Health Exchange (CGHE)* program. This will authorize us to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you.

I acknowledge that I have been given sufficient information to understand the permission I am giving in this document, and that I have had the opportunity to have my questions answered about the *Central Georgia Health Exchange*. I understand that until I have given permission to create a CGHE record, this information will not be used to update the Central Georgia Health Exchange. I give permission to those described below to use and disclose my Information, as described below.

Yes, I agree to participate in the Central Georgia Health Exchange

No, I do not agree to participate in the Central Georgia Health Exchange

\_\_\_\_\_  
*Printed Name of Patient/Representative*  
AUTHORITY OF REPRESENTATIVE:

\_\_\_\_\_  
*Signature of Patient/Representative*

\_\_\_\_\_  
*Date*

I, \_\_\_\_\_, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis:

Relationship to Patient: \_\_\_\_\_

[A signed copy of this permission will be provided to the patient/representative]

The Central Georgia Health Exchange is an exciting program designed to improve your healthcare and make office visits easier and more convenient. This authorization will allow your doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through an electronic **medical record system**, known as the Central Georgia Health Exchange. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The *Central Georgia Health Exchange* will allow **your providers** access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize **Forsyth Street Orthopaedics** to use and disclose **demographic**, insurance, and medical information related to my treatment (the "Information"), and to make such Information available through the Central Georgia Health Exchange to other healthcare providers who need access to my Information for the purposes described in this document. The Information **may include**, but is not limited to the following: **Information contained in** medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of stays of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

You may already have authorized the sharing of your Information into the Central Georgia Health Exchange by signing a permission form when visiting the office of another doctor who participates in CGHN. Due to differences in various computer systems, this specific authorization is required by law to release your Information from **Forsyth Street Orthopaedics** to the Central Georgia Health Exchange. If it is determined that you already have authorized disclosure of your Information to the Central Georgia Health Exchange by signing a consent in another participating CGHE practice, then we will update your Information on the CGHE with the information from **Forsyth Street Orthopaedics**, consistent with your previous permission. If it is determined that you have NOT previously authorized disclosure of your Information to the Central Georgia Health Exchange, then the Information disclosed by **Forsyth Street Orthopaedics** will NOT be used to update the CGHE.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to redisclosure. However, the *Central Georgia Health Exchange* system incorporates access controls, encryption technology and other security features designed to protect the privacy and security of your Information. In addition, access to the *Central Georgia Health Exchange* will be limited to only those users who have agreed to use the *Central Georgia Health Exchange* consistent with your permission. Information shared through the *Central Georgia Health Exchange* can be used for the following purposes and disclosures: Clinical care; Quality monitoring and improvement; and Administrative management of the Central Georgia Health Exchange

You can learn more about the *Central Georgia Health Exchange* by reading the information booklet, "A Guide To The Central Georgia Health Exchange" that is available at the CGHE website (<https://www.CGHE.net>) or on request from your doctor's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Health Exchange, 777 Hemlock Street, Hospital Box 98, Macon, GA 31201. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

**I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that a Central Georgia Health Exchange record will not be available to other providers (including The Medical Center of Central Georgia).**