NORTHVIEW ORTHOPAEDIC ASSOCIATES
Orthopaedic Surgery - Sports Medicine - Open MRI - Physical Therapy
Alan Binkley, MD - David Hochschild, MD - Ray Polk, PA

Patient Information:

Patient Name_____ Gender: Male or Female

Marital Status: M S D W Date of Birth:_____ Are you in school? YES NO / Full Time or Part Time

Patient SSN#:_____ Race:_____ Ethnicity:_____

Primary Language:_____ Referring M.D:_____

Primary Phone #:_____ Secondary Phone #:_____

Mailing Address:_____ City:_____

State:_____ Zip:_____

Physical Address (if different):_____ City:_____

State:_____ Zip:_____ Email Address:_____

Is patient in Skilled Nursing Facility? Yes or No/ Name of Nursing Facility:_____

Is patient currently under Hospice Care? Yes or No/ Name of Hospice Company:_____

Is patient employed? YES NO / Full Time or Part Time Employer Name & Phone#:_____

Emergency Contact:_____ Phone #:_____

Guarantor Information: (Guardian or Person responsible for your bill if not yourself. Ex: Under 18)

Guarantor Name:_____ Rel to Patient:_____ D.O.B_____

Address:_____ City:_____ State:____

Zip:_____ Phone #:_____ Work #:_____

Guarantor SSN:_____ Are you employed? YES NO / Full Time or Part Time

Employer Name and Phone #: _____

Insurance Information (Complete Policy Holder information is needed to properly file claims)

Primary Insurance Type:_____ ID#:_____

Policy Holder:_____ D.O.B:_____ SSN:_____ Rel to Patient:_____

Secondary Insurance Type:_____ ID#:_____

Policy Holder:_____ D.O.B:_____ SSN:_____ Rel to Patient:_____

Is the insurance through Policy Holder's employer? YES NO

If Medicare is secondary, please list why:_____

Is this a work related injury? YES NO

HIPPA: Acknowledgment of Privacy Practices

The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

I list the following Authorized Individuals to have access to my medical records and their relationship to me:

Name:_____ Relationship to patient:_____

Name:_____ Relationship to patient:_____

_____ _____

Patient or Guardian's Signature Today's Date

NORTHVIEW ORTHOPAEDIC ASSOCIATES

Orthopaedic Surgery - Sports Medicine - Open MRI - Physical Therapy

Alan Binkley, MD - David Hochschild, MD - Ray Polk, PA

Patient History

Name or nick-name:_____ Age:_____Marital Status(cirlce): S M W D

Weight_____ Height_____ Occupation:_____

Patient is living with: ☐ Self ☐Both Parents ☐Spouse ☐Mother ☐Father ☐Other ☐Right Handed ☐Left Handed

Do you have any Family History of the following: ☐ Heart Trouble ☐ Cancer ☐ Rheumatoid Arthritis ☐ Osteoporosis

☐Cigarettes: Packs/day:_____ ☐Cigar/Pipe ☐Dip/Snuff ☐Drugs: Type:_____ ☐ Alcohol: Drinks per week:_____

Do you currently have the flu or experiencing flu like symptoms? ☐ Yes ☐ No Explain:_____

Current Problem:

1. List the area of the problem:_____
2. How did the problem begin? ☐Lifting ☐Twisting ☐Falling ☐Car Accident ☐Unknown ☐Other:_____
3. Date of injury, first occurrence, or became recently worse:_____ Was the onset ☐ Gradual or ☐Sudden
4. Have you been hospitalized for this problem?_____ Dates & Hospital:_____
6. Have you had any of the following tests for this condition? Dates & Location:_____

☐ X-Rays ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Other:_____

Medical History:

1. Have you ever been diagnosed as having any of the following? Please check where applicable:

☐ Seizures	☐ High Blood Pressure	☐ Elevated Cholesterol	☐ Respiratory Problems	☐ HIV
☐ Cancer	☐ Tuberculosis	☐ Chemical Dependency	☐ GI Problems	☐ Stroke
☐ Diabetes	☐ Hepatitis	☐ Other Arthritic Conditions	☐ Sedentary Life Style	☐ Arthritis
☐ Thyroid	☐ Kidney Disease	☐ Anesthesia Complications	☐ Heart Trouble	☐ Depression

☐ Other:_____

2. Are you currently or in the past 6 months being seen by any of the following? Check where applicable:

☐ Speech Therapist ☐ Dentist ☐Psychologist/Psychiatrist ☐ Osteopath ☐ Chiropractor

☐ Medical Doctor ☐ Physical/Occupational Therapist ☐ Other:_____

3. Have you ever had a fracture or dislocation? _____ What body part?_____
4. Are you pregnant or is there a possibility that you are pregnant? ☐ Yes ☐ No
5. Do you have any metals or plastics in your body? ☐ Rods ☐ Pins ☐ Plates ☐ Metal from gunshot ☐ Artificial Joints

☐ Staples ☐ Screws If so, where?_____

Primary Care Doctor: _____

List any past surgical procedures or hospitalizations with dates: _____

_____

_____

Current Medications: _____

_____

_____

_____

List known drug allergies & reactions:_____

Review by Clinician: _____ Date: _____ Reviewed by Doctor: _____ Date: _____

Northview Associates
70 Ansley Drive
Dahlonega, GA 30533

Telephone: 706-864-7904
Fax: 706-864-0432

HIPAA Privacy Rights Request Form

PATIENT INFORMATION

Date _____

Name (Last, first, middle initial) _____ Date of Birth _____

Street address _____ City _____ State _____ ZIP Code _____

Primary phone number _____ Other phone number _____ E-mail address _____

Type of Request ☐ **From Northview Associates** ☐ **To Northview Associates**

☐ Discharge Summary ☐ History and Physical ☐ Operative Note
☐ Consultation (s) ☐ Pathology Report ☐ Lab
☐ X-ray / MRI report ☐ X-ray / MRI Films or Discs ☐ All Records
☐ Other (Specify) _____

This Information may include, but not limited to, treatment related to psychiatric or psychological, drug and/or alcohol, or Acquired Immune Deficiency Syndrome/HIV.

I understand that this consent is subject to revocation by me any time, and unless an earlier date is specified, the consent will automatically expire 90 days after the date below. I also understand that this information may be bound by Title 42 of Code of Federal Regulations governing the confidentially of alcohol and drug abuse patient records. Re-disclosure of this information to any party than the one listed is prohibited without additional written consent on my part.

Additional Information:

_____

_____

_____

_____

Patient/Guardian _____ Date _____

Relationship if not signed by patient _____ Date _____

Witness Signature _____ Date _____