Winston Bone & Joint Surgical Associates, P.A.

Kenneth G. Tomberlin, MD Thomas C. Spangler, MD

Patient Information

Last Name: First Name: Middle Goes by:

Social Security #: Date of Birth: Male/Female:

PO Box & Street Address:

City/State/Zip

Home Phone: Cell Phone: Work Phone:

E-mail address: Race: Language: Ethnicity:

Emergency Contact: Relationship Home Phone: Cell Phone:

Family Physician: Referring Physician:

Insurance Information

Primary Insurance: Secondary Insurance:

(Please bring your card to the desk for us to scan)

Policy Holder's Name: Relation: SS#: Date of Birth:

Injury/Onset Date **Is this worked related? (If yes, please supply worker's comp info to front desk)**

Are you in a nursing home or extended care? Facility Name

Pharmacy Information

Pharmacy Name/Location: Phone Number:

Address:

I give my permission to download my medications from my pharmacy.

_____

Signature: **Date:**

Injury/Problem Information

Name: **Today's Date**

Height: Weight: Right Handed or Left Handed:

Main Problem Left or Right Side Date of Injury

Describe the Accident/problem:

Is it work related? Auto Accident?

Previous Treatment (including physical therapy, home exercises and anti-inflammatory medicines):

Have you had an xray? MRI or CT scan? PNCV/EMG? Bone Scan?

(Please list when & where):

Have you seen another MD for this problem? Treating Physician:

Medications

List all medications you take, prescription and over the counter and their dosage.

Medication: **Dose/mg:** Frequency:

_____

_____

_____

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_____

_____

Drug Allergies

Please list drug allergies AND REACTION.

Penicillin ☐ yes Reaction:_____

Sulfa ☐ yes Reaction:_____

Caines/Numbing medicine ☐ yes Reaction:_____

Aspirin ☐ yes Reaction:_____

Codeine ☐ yes Reaction:_____

Other: _____

_____

Latex ☐ yes Reaction:_____

Xray Dye ☐ yes Reaction:_____

Past Medical History

Please indicate if you have ever experienced any of the following conditions. Include the date of experience or onset if applicable.

	✔
Hypertension – High Blood Pressure	
Claustrophobic	

	✔
Diabetes	
On Blood Thinning Medicine	

	✔
CAD – Heart Disease	
Pacemaker	

	✔
AIDS/HIV	
Alcoholism	
Alzheimer's	
Anemia	
Angina – Frequent chest pain	
Arthritis	
Asthma	
Benign prostatic hypertrophy	
Cancer	
Type:	
Cerebrovascular accident/**Stroke**	
Congestive heart failure	
COPD/Emphysema	
Coronary artery disease	
Crohn's disease	
Dentures	
Depression	
Drug Abuse	
DVT – Blood Clot	
Fibromyalgia	

	✔
Gallbladder disease	
GERD/Reflux	
Gout	
Hepatitis	
Hyperlipidemia/High **Cholesterol**	
Inflammatory bowel disease	
Juvenile rheumatoid arthritis	
Kidney disease	
Liver disease	
Lyme disease	
Migraine headaches	
Multiple sclerosis	
Myocardial infarction/**heart attack**	
Obesity	
Osteoporosis	
Parkinson disease	
Psoriasis	
PVD/peripheral artery disease	
Rheumatoid arthritis	
Scoliosis	

	✔
Seizure disorder	
Sleep apnea	
SLE/Lupus	
Spinal stenosis	
Thyroid Disease	
Valvular heart disease	
Aneurysm	
Anxiety	
Chronic bronchitis	
Colitis	
Hyperthyroidism	
Irregular heart beat/arrhythmia	
Low blood pressure/hypotension	
Stomach ulcer	
Tuberculosis	
Other:	

Patient Name:

Surgical History

Please check all that apply.

	✔	Year:	Left or Right?
ACL surgery			
Angioplasty			
Angioplasty w/stent			
Appendectomy			
Arthroscopy ankle			
Arthroscopy elbow			
Arthroscopy hip			
Arthroscopy knee			
Arthroscopy wrist			
Arthroscopy shoulder			
Back surgery			
CABG/Open heart surgery			
Cardiac valve replacement			
Carpal tunnel release			
Cataract extraction			
Cholecystectomy			
Gastric bypass			
Hernia Repair			

	✔	Year:	Left or Right?
Hip replacement			
Knee replacement			
Laminectomy			
LASIK			
Meniscus surgery			
Muscle biopsy			
ORIF			
Type:			
Small bowel resection			
Thyroidectomy			
Tonsillectomy			
Cesarean section			
Hysterectomy			
Lumpectomy			
Mastectomy			
Prostate biopsy			
Vasectomy			

Previous Fractured Bones: _____ _____

Other surgery: _____

Family History

Please indicate if a member of your immediate family has had or currently has any of the listed conditions. Please indicate the cause of death.

☐ Adopted

	Mother	Father	Brother	Sister
Diabetes				
Heart Disease				
Cancer (type)				
Lung Disease				
Alzheimer's disease				
Depression				
Osteoporosis				
Rheumatoid Arthritis				
Gout				
COPD				
Stroke (CVA)				
Other:				
Cause of death				

Patient Name:

Social History

Employer: Occupation: Describe your job duties:

Tobacco Usage:

Please circle which applies: *Current smoker/tobacco user * Former smoker/tobacco user *Never smoker/Never used tobacco

If you use or used tobacco: Type:_____Packs per day (cans, cigars, etc.):__ Years smoked:____ Age Quit:_____

Alcohol Usage:

Do you drink alcohol? Yes/No (circle one) Type: _____ Frequency:_____

Marital Status:_____ How many people live in your house or apartment? ____

Can we leave a message on your phone regarding appointments, lab results, study results and medical information? _____

Do you preferred to be contacted by mail, home phone, cell phone or email? Please circle all that apply.

Do you want to use our Patient Portal? YES/NO/Already enrolled Email required:_____

Please list with whom we may Discuss your Medical History and their relation to you

Name	Relation	Phone
Name	Relation	Phone
Name	Relation	Phone

Financial Responsibility & Record Release Or Receive

The undersigned guarantees payment to Winston Bone & Joint Surgical Associates, PA for the services rendered including deductibles, co-payment and non-covered serves. I hereby authorize payment directly to Winston Bone & Joint Surgical Associates, PA for any services that I may receive during my treatment.

When you provide us with a wireless telephone number or land line number, you are giving us your prior express consent to call that number.

I authorize Winston Bone & Joint Surgical Associates to release or receive any medical information from any medical facility or physician, insurance company, attorney, assignees or beneficiary requesting information whether past, present or future.

Signature of patient or guardian Date Witness

Patient Name:

WINSTON BONE & JOINT
SURGICAL ASSOCIATES

3817 Forrestgate Drive Winston Salem, NC

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HIPAA Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that your reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, it you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____

_____

Signature of patient or guardian Date Witness