Patient Name: _____ Today's Date:_____
Filled out by: _____ Signature: _____
Mother's Name:_____ Occupation:_____
Father's Name:_____ Occupation:_____

Date of Injury or Duration of Symptoms: _____

Past Medical History

Birth Date: _____
Full Term or Premature (# of Weeks) _____
Vaginal or C-Section (Reason for C-Section) _____
Breech (foot first) NO YES
Complications of Labor and/or Delivery: _____

Medical/Surgical History

Does your child have any medical conditions (asthma, diabetes, cerebral palsy, etc) NO YES
Please Describe: _____
Has your child ever had surgery: NO YES _____
Does your child take any medications: NO YES _____
Any allergies to medications: NO YES _____

Family History

Does anyone have a history of a similar condition, arthritis, cerebral palsy, muscular dystrophy, bone or joint problems or scoliosis: NO YES (please explain)

_____

Social History

With whom does the child live (include siblings and ages):_____
_____
What grade in school: _____
Favorite sports/activities: _____
Milestones: At what age, in months, did your child:
Roll over_____ Sit unsupported _____ Crawl _____ Pull to stand _____ Walk _____

Systems Review Circle Yes or No - Please explain "yes" answers – use back if needed
Is your child having:

- Fatigue, lethargy ----------N Y
- Visual disturbances ----------N Y
- Heart murmur or palpitations----------N Y
- Congenital heart defect----------N Y
- Asthma, difficulty breathing----------N Y
- Nausea, vomiting, diarrhea, constipation---- N Y
- Bedwetting, frequent urinary infections---- N Y
- Aches or pains in the bones/joints----------N Y
-
- Rashes, multiple birthmarks----------N Y

- Numbness, tingling in the extremities--------N Y
- Burning pain in the extremities----------N Y
- Depression, Anxiety, ADHD----------N Y
- Fevers/chills/night sweats----------N Y
- Racing / slow pulse----------N Y
- Easy bruising or bleeding----------N Y
- Fever, Frequent Infections----------N Y
- Other symptoms we should know about---N Y

What, in your own words, is the reason for your visit?

_____

_____

Who is the child's pediatrician?
Name:_____

GEORGIA Pediatric Orthopaedics

_____
ERIC LINCOLN, D.O.

PATIENT INFORMATION — PLEASE PRINT

Patient Information: Today's Date: _____ Referred by: _____

Patient Name _____
First *Middle* *Last* *Nickname*

Address _____ P.O./Apt # _____

City _____ State _____ Zip _____

Phone Number _____ Patient Social Security Number _____

Date of Birth _____ Sex ☐ Male ☐ Female Marital Status: _____

Guardian Information::

Parent/Guardian Name _____ Parent/Guardian Social Security #: _____

Guardian Date of Birth _____ Relationship to Patient _____

Employer Name _____ Employer Number _____

Employer Address _____
City *State* *Zip*

Day Time Phone: ( ) _____ Cellular Phone Number: ( ) _____

Email Address: _____ Pager Number: ( ) _____

Emergency Contact: *List most important first*

1)Name _____ Phone Number _____ Relationship _____

2)Name _____ Phone Number _____ Relationship _____

Billing Information: Responsible Party *if other than patient*

Billing Name _____
First *Middle* *Last*

Address _____

City _____ State _____ Zip _____ Phone Number _____

Insurance Information: Please provide copies of all Medical Insurance and complete the following:

Primary Cardholder _____
First *Middle* *Last* *Insurance Company Name*

Address _____ Phone Number _____

Insured's DOB _____ Insured's Sex ☐ Male ☐ Female Social Security Number _____

Employer Name/Address _____
Employer Phone Number

Secondary Cardholder _____
First *Middle* *Last* *Insurance Company Name*

Address _____ Phone Number _____

Insured's DOB _____ Insured's Sex ☐ Male ☐ Female Social Security Number _____

Employer Name/Address _____
Employer Phone Number

"I certify the information given above by me is correct. I hereby authorize the release of any medical or other information to any third party payors to be used by them in consideration of payment of any claims resulting from my treatment. I will not hold this health care entity or its providers responsible for further dissemination of my medical information by the third party. I also authorize release of said information to and from my physicians, state or federal agencies, or other health care providers if needed for continuity of care, quality assurance or utilization review purposes. I authorize this facility, and such professional staff and aids it may designate to carry out such procedures, to administer treatment, and perform such care as indicated. I consent to the performance of those medical treatments and/or procedures in addition to or different from those now contemplated, that may arise from presently unforeseen conditions that may occur during my treatment. I further assign benefits to the physician and understand and agree that I am responsible for any balance due after insurance has been filed. A copy of this authorization may be used in place of the original."

Signature _____ Date _____

Georgia Pediatric Orthopaedics
840 Pine St Suite 500
Macon, GA 31201

_____

Patient's name Legal Guardian's name

_____

Patient's DOB Social Security Number

I,_____(parent/guardian) do hereby authorize GPO to discuss the medical treatment, results of any labs or x-rays or other procedures for _____(patient name) with the following individual(s):

Name Relationship

1)_____

2)_____

3)_____

4)_____

Due to my signature below on this authorization GPO will not be held liable if my medical treatment is discussed or released to the above-referenced persons. This authorization will be in effect until such time as I change the person(s) referenced or withdraw permission.

I specifically do not authorize any medical treatment to be discussed with the following individual(s).

1)_____

2)_____

Date_____ Signature_____

Patient/ Legal Guardian

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Orthopaedics

Cancellation Policy

Office Appointments:

If you must cancel or reschedule your appointment for any reason, please call as early as possible; preferably at least 48 hours in advance. This enables us to see patients with urgent needs more efficiently. Failure to notify us at least 24 hours in advance may result in a $25.00 missed appointment fee. Missed appointments are subject to a prepayment charge prior to rescheduling and cannot be filed to insurance. Multiple missed appointments may result in the practice no longer being able to care for the patient.

Procedures:

If you must cancel or reschedule your procedure for any reason, please call as early as possible; at least **48 hours in advance**. Failure to notify us at least 48 hours in advance may result in a $50.00 missed procedure fee. Missed procedures are subject to a prepayment charge prior to rescheduling and cannot be filed to insurance. Multiple missed procedures may result in the practice no longer being able to care for the patient.

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Acknowledgement of Cancellation Policy:

I have read and understand the Office Appointment and Procedure Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of Georgia Pediatric Orthopaedics Cancellation Policy.

_____

Printed Name of the Patient or Responsible Party Date

_____

Signature of Patient or Responsible Party Date

GEORGIA
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Orthopaedics

CENTRAL GEORGIA HEALTH SYSTEM
NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices

I have been offered a copy of the Central Georgia Health System Notice of Privacy Practices.

_____ _____

Patient Signature Date

_____ _____

Witness Date

Comments: _____

_____

_____

_____

HEALTH SERVICES OF CENTRAL GEORGIA

PATIENT FINANCIAL RESPONSIBILITY FORM

Patient's Name:_____Date of Birth:_____

Basic Policy: Services provided by our physician should be paid in full at the time services are rendered. ***Pt. Initials:***_____

Non-covered services: A payment for non-covered charges is expected at the time services are rendered. ***Pt. Initials:***_____

Elective (Cosmetic) services: Payment in full is required prior to seeing the service provider. ***Pt. Initials:***_____

Missed Appointments: If a patient cannot present for an appointment, he/she should cancel the appointment (2) business days prior to the scheduled appointment time. Untimely notification and no-shows may result in charge that is not covered by insurance carriers. ***Pt. Initials:***_____

Patients with insurance: In accordance with insurance carrier contracts, patients will be required to pay their ***Co-payment.*** HSCG will submit charges for services rendered to the insurance carrier. If the insurance carrier determines there is a patient balance owed a statement will be sent. All balances should be paid upon receipt of statement. ***Pt. Initials:***_____

Returned checks: Payments made by check to HSCG that are not honored by the bank will incur a returned check fee of $30.00. ***Pt. Initials:***_____

I have read, understand, and agree to the above financial agreement for payment of all fees. The patient/guarantor is ultimately responsible for all fees.

Patient's Signature:_____**Date:**_____

Assignment of insurance benefits:

I hereby assign all medical insurance benefits to which I am entitled, private insurance, and any other health plans to HSCG. I authorize HSCG to release all information necessary to secure the payment for services rendered. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Patient's Signature:_____**Date:**_____

HEALTH SERVICES OF CENTRAL GEORGIA

Medicare Patients: HSCG is contracted with Medicare to accept assignment of benefits. HSCG will submit charges for services rendered. In accordance with Medicare guidelines patients will be required to pay the 20% coinsurance. If applicable, secondary insurance will be filed. I understand that the physician may order medical services not covered by Medicare and I will be financially responsible for these services.

Pt. Initials:_____

Medicare patient's signature on file:
I request payment of authorized Medicare benefits be made on my behalf and behalf of HSCG for any services furnished me by the listed providers/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payments be made, and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurance or agency shown, in Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductibles, co-insurance and non-covered services.

Patient's printed name:_____

Patient's Signature:_____