ATLAS

ORTHOPAEDICS *total orthopaedic care*

Duncan Wells, M.D., P.C. 970 Woodstock Pkwy. Suite 310 Woodstock, GA 30188 770-517-2257 Fax 1-877-447-4190

Patient Name:______________________________ Date:__________

Birth Date:__________ Sex M / F SS#_____-_____-_____ Marital Status:__________

Address:______________________________City,State:______________Zip:________

Height:______ Weight:______ Email Address: ______________________________

Home# (   )______-______ Cell# (   )______-______ Work# (   )______-______

Is your visit due to a Job Related Injury or Automobile Accident ? YES NO

Employer Name:______________________________Employer Phone#:______________

Primary Care Physician:______________________________Phone#:______________

Has another member of your family been treated by Dr Wells before?______ Name:______________

How did you hear of us?______________________________

Who To Contact For An Emergency (*different household*)

Name:______________________________ Relationship:______________

Home# (   ) ______-______ Cell# (   ) ______-______ Work# (   ) ______-______

Person Responsible for Bill (Complete only if not the patient) Relationship to Parent:______________

Guarantor Name:______________________________Date of Birth:_____/_____/_____

Address:______________________________City,State:______________Zip:________

SS#_____-_____-_____ Home#:(   )______-______ Cell#: (   )______-______

Employer Name:______________________________Employer Phone:(   )______-______

Primary Insurance: Insurance Name:______________________________

Policy Holder:______________________________ Date of Birth: _____/_____/_____

ID#: ______________________________ Group#: ______________

Secondary Insurance: Insurance Name:______________________________

Policy Holder:______________________________ Date of Birth: _____/_____/_____

ID#: ______________________________ Group#: ______________

_______ I authorize Duncan Wells M.D. to release to my insurance carrier(s) and / or CMS (formally HCFA and its agents any information needed to determine benefits or benefits payable for related services.

X______________________________ Date:______________________

Patient or responsible party Signature

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Chief Complaint Form:

Date: ____________________

Patient Name: ____________________ ____________________
First MI Last Preferred Name

Age: ______ DOB: __________ Occupation: _______________ Employer: ____________________

Referring Physician: ______________________________ Phone#: ____________________

Primary Care Physician: ______________________________ Phone#: ____________________

Body part being seen for: ____

Side of Body: (circle) Right Left Both

Date Symptoms Began: ____________________

Was there an injury? (circle) Yes No

Workers Comp? (circle) Yes No

If so, how did it happen?

____

____

Current Symptoms: ____

If there is pain, where is it located? ____

Are your symptoms? (circle) Improving Worsening Stable

Are your symptoms? (circle) Mild Mild/Mod. Moderate Mod./Severe Severe

What activities or body positions make your symptoms worse?
(ex. Walking, running, reaching overhead)

____

____

Have you had prior treatment? (ex. Injections, surgery, physical therapy)

____

____

Patient Name:____________________________ **Date:**____________________________

Medical History:

Check if you have had any of these **medical problems** in the PAST:

MAJOR ILLNESS	YES	NO	**MAJOR ILLNESS**	YES	NO
Anemia			Liver Disease		
Arthritis			Kidney Disease		
Heart Arrythmia / Palpitations			Loss of Vision		
Asthma			Mitral Valve Prolapse		
Bleeding Problems			Neuropathy		
Blood Clots			Paralysis		
Cancer: Type__________			Peripheral Vascular Disease		
Chest pain / Angina			Pneumonia		
Diabetes			Psychiatric Illness		
Gall Bladder Disease			Pulmonary Embolism		
Gastric Ulcers			Reflux		
Glaucoma			Skin Ulcer/Breakdown		
Heart Attack			Steriod Use		
Heart Failure			Stroke		
Heart Murmur			Thyroid Disease		
Hepatitis B			Tuberculosis-TB		
Hepatitis C			Urinary Infections		
High Blood Pressure			Valve Disorders (heart)		
HIV/Aids			Wound Healing Problems		
Immune Deficiency			Orther:____________		

Please list any **operations / surgeries** you have had:

SURGERY/REASON		**YEAR**	**SURGERY/REASON**		**YEAR**
1)			5)		
2)			6)		
3)			7)		
4)			8)		

Please list any Medications that you are currently taking:

MEDICATION AND DOSE			**MEDICATION AND DOSE**		
1)			6)		
2)			7)		
3)			8)		
4)			9)		
5)			10)		

Do you have any allergies to medications/substances? YES NO

If YES, please list below:

ALLERGIES			**ALLERGIES**		
1)			5)		
2)			6)		
3)			7)		
4)			8)		

Name:______________________________ **Date:**________________________

FAMILY MEDICAL HISTORY: Please list major illness that affect immediate family:

MAJOR ILLNESS	**RELATION**	**MAJOR ILLNESS**	**RELATION**
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

Social History:

Alocohol use: Yes No Drinks per week: ________________

Cigarette use: Yes No Packs per day:______ Years:_______

Smokeless Tobacco use: Yes No Years:___________

Illicit Drug use: Yes No Type:____________

Review of Symptoms: Please mark any of the symptoms that apply to you TODAY:

SYMPTOM	YES	NO	**SYMPTOM**	YES	NO
Tarry Stools			Frequent Urination		
Vomiting			Urgent Urination		
Abdominal Pain			Painful Urination		
Chest Pain			Muscular Weakness		
Irregular Heart Beat			Numbness or Tingling		
Rapid Heart Beat			Joint Pain or Swelling		
Swelling of Legs			Muscle Pain or Swelling		
Cough			Frequent/Easy Bruising		
Shortness of Breath			Cuts that don't stop Bleeding		
Rash			Anxiety		
Wound Healing Problem			Depression		
Fever/Chills			OTHER:		

Agreement of Accuracy: The information provided in this history form is true and complete to the best of my knowledge.

X____________________________________ Date:____________________

How were you referred to our practice? (Circle)

Physician Newspaper Radio Healthsource Insurance

Friend/Relative:______________________________

Other:____________________________________

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All professional services are charged to the patient. Necessary forms will be completed to help expedite your insurance carrier payments. However, the patient is responsible for all fees regardless of insurance coverage. Fees are payable at the time of examination. Should patient fail to pay as agreed above then the patient shall be liable for all costs and expenses of Atlas Orthopaedics incurred including all finance charges, all attorney fees and court costs. I understand that in the event I fail to make payment to my account, it will be turned over to collections and a 40% collection fee is charged as well as any additional interest by the collection agency. This balance is the responsibility of the patient.

I request that payment of authorized insurance carrier benefits be made on my behalf to Dr Duncan Wells, M.D. for any services furnished me by that practice. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits. I understand that my signature requests that payment be made to Atlas Orthopaedics and authorizes release of medical information to pay any claims. In Medicare or other insurance carrier assigned cases, the practice agrees to accept the charges of said insurance carrier as the full charge and the patient is responsible only for the deductible, co-pays, co-insurance and non-covered services. A copy of this authorization shall be valid as the original.

HIPPA (Health Insurance Portability and Accountability Act of 1996): If you would like to receive a copy of HIPPA please see receptionist. This is to acknowledge that I have read and received a copy of the privacy practices.

I hereby authorize Atlas Orthopaedics, Dr Wells and his staff to release medical information to or speak with the following people in regards to my account or medical conditions:

Authorized Person Name________________________________ Number_________________________

I hereby authorize Atlas Orthopaedics, Dr Wells and his staff to leave a voice message, text and/or send an email for appointment reminders:

Cell Phone: ___________________________ Email: _____________________________________

Patient Name: _____________________________________Date: ________________________

Patient Signature: ____

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PATIENT NO SHOW AND COPAY POLICY

- No shows and cancellations with less than 24 hrs. notice are a significant problem for medical practices
- We like to spend time with our patients and the physicians time is specially allotted for him to care for each patient

We understand that things occasionally come up and that appointments are sometimes forgotten, therefore, we do not charge for the first No Show especially if a patient call prior to his or her appointment time. **For all additional no shows, there will be a $20.00 No Show fee for any missed appointments, Also there will be a $200.00 No Show fee for missed surgery appointment not cancelled 24 hrs. in advance. This charge is not covered by insurance.**

Our practice does not see walk in appointments. To schedule an appointment, call 770-517-2257. Our administrative staff will schedule your follow-up appointments. Same day appointments will only be scheduled on an emergency basis.

Patients arriving on time are seen at their appointment times. Patients arriving on time will be seen ahead of those arriving late. If you arrive more than 15 minutes late, we may need to reschedule your appointment. Call ahead if you are going to be late. We will advise you if we will be able to see you or if you will need to reschedule. TO AVOID DELAYS PLEASE ALWAYS ARRIVE ON TIME FOR APPOINTMENTS.

Patients will be seen for the issue or injury they discussed when scheduling their appointment. If a patient has multiple problems that are not discussed at the time of appointment, we may need to schedule more time or arrange another appointment for these issues. Please advise what issues you would like addressed when scheduling appointments.

Copay amounts are due at the time of service. If you are unable to make your copay at the time of your appointment, **there will be a $15.00 administrative billing fee that you will be responsible for in addition to your copay.**

We accept VISA, MC, DISCOVER, AMEX, CHECKS AND CASH. If paying by cash, please make sure you have the correct amount as we do not keep change in the office. Please make sure you are given a receipt when paying with cash.

If you have any questions in reference to these policies or any questions in general about our practice, please feel free to contact us at 770-517-2257. You may also contact our office manager Misty Kennedy, atlasortho@bellsouth.net. We appreciate your confidence in our practice.

X____ Date: ______________________________

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PAIN MEDICATION AND REFILL POLICIES

Due to newly published guidelines by the American Medical Association and the Academy of Orthopaedic Surgeons, below is our policy for PAIN MEDICATION AND REFILLS.
Narcotic pain medication will be given for a 4 week post operative period ONLY and on rare occasions pre-operatively.
Pain medication for problems that do NOT require surgery will only be given for acute SHORT TERM pain.
If you are suffering from chronic pain, we will be happy to assist you in locating a pain management specialist.

1. I agree to allow **48 hours** for prescription refills.
2. I understand that a follow-up visit may be required from Dr. Wells in order to obtain a refill.
3. I agree to take all medication EXACTLY as prescribed by Dr. Wells. I will NOT change the dosage or alter the time schedule without first speaking to Dr. Wells or his nurse.
4. Prescription medication WILL NOT be refilled after business hours or on the weekends. Our office is closed on Friday
5. Patients may be terminated from the practice without notice for noncompliance in taking of their medications, obtaining narcotics from another physician while under the care of Dr. Wells or altering/forging a prescription. **THIS IS A FELONY AND WILL BE PROSECUTED TO THE FULL EXTENT OF THE LAW.**
6. Atlas Orthopaedics/Duncan Wells MD **WILL NOT** refill prescriptions that have been lost or misplaced.
7. I understand that I must keep all scheduled appointments as recommended by Dr. Wells.
8. I will not combine any narcotic medication with the consumption of alcohol or any illegal substance.
9. Only one pharmacy may be used for prescriptions. If my pharmacy changes I will notify the office.

Pharmacy of choice ______________________ Phone ______________________.

I have read the above prescription policies and I understand and agree to abide by them. I understand that if I refuse to sign this policy form, Dr. Wells may refuse to prescribe medications.

Patient Name: ______________________ **Date:** ______________

Signature: ______________________________________