Foothills Orthopaedics & Sports Medicine Center
3150 Hwy 153 | Piedmont, SC 29673
Phone 864-295-1231 | Fax 864-295-0095
Anne-Claire Edwards, MD | John P. Evans, MD | Clark Jernigan, MD
Daniel E. Lee, MD | Marc Tanner, MD | Janice Lee, FNP-C

Patient Intake Paperwork

Name: ______________________________________ Today's Date: ______________________

DOB: _________________________________ SSN: __________-__________-__________

Email: ____

Mobile Phone: __________________________ Home Phone: __________________________

Address: ____

City: ______________________________ State: ________ Zip Code: ___________________

Race: _____________________________ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Preferred Language: ☐ English ☐ Other: ____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Significant Other

Primary Care/Family Doctor: ____

Other Current Physicians: ____

May we provide copies of your visit notes to these providers? ☐ Yes ☐ No

Past Medical History

Major events, hospitalizations, surgeries, etc: ____

____

____

Drug Allergies, Food/Environmental Allergies:____

Ongoing Medical Problems

Have you ever been diagnosed with:

☐ Acid Reflux ☐ Addiction ☐ Anxiety ☐ Atrial Fibrillation

☐ Bloody Urine ☐ Bloody Stool ☐ Bone Disease ☐ Bradycardia

- [ ] CAD
- [ ] ________ Cancer (please specify)
- [ ] Heart Disease
- [ ] Lupus
- [ ] Obesity
- [ ] Pain Management
- [ ] Renal Disease
- [ ] Swollen Feet
- [ ] Hypothyroidism
- [ ] Chronic back pain
- [ ] Joint Pain
- [ ] Depression
- [ ] High Cholesterol
- [ ] Migraines
- [ ] Osteoarthritis
- [ ] Palpitations
- [ ] Seizures
- [ ] Hyperthyroidism
- [ ] Other: ________
- [ ] Clotting Disorder
- [ ] Eating Disorder
- [ ] HIV/AIDS
- [ ] MS
- [ ] Osteoporosis
- [ ] Parkinson's
- [ ] Stomach Ulcers
- [ ] Visual Problems
- [ ] Kidney Disease
- [ ] COPD
- [ ] Gout
- [ ] Hypertension
- [ ] Muscle Pain
- [ ] Paget's Disease
- [ ] PAD
- [ ] Stroke
- [ ] Diabetes
- [ ] Liver Disease

Have you broken a bone? ☐ Yes ☐ No If yes, what bone? __________________ Age: _________

Were you treated? ☐ Yes ☐ No If yes, where? ____

Have you ever had chemotherapy or radiation therapy? ☐ Yes ☐ No

Do you have a chronic pain doctor? ☐ Yes ☐ No If yes, who? ____________________________

Family Medical History

Have any of your grandparents, parents, siblings, or children been diagnosed with the following:

Cancer ☐ Yes ☐ No. Which type? _____________ Which family member(s)? _______________

Diabetes ☐ Yes ☐ No. Which family member(s)? ______________________________________

Heart Disease ☐ Yes ☐ No. Which family member(s)? __________________________________

Hypertension ☐ Yes ☐ No. Which family member(s)? ___________________________________

High Cholesterol ☐ Yes ☐ No. Which family member(s)? _______________________________

Arthritis ☐ Yes ☐ No. Which family member(s)? _______________________________________

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks do you have per week? ___________

Do you smoke or use chewing tobacco or snuff? ☐ Yes ☐ No

If yes, how many packs do you use per day? ____

Have you had your flu shot for this year? ☐ Yes ☐ No

Policy Agreement

I received a copy of the financial and controlled substance policies for patients of Dr. W. Clark Jernigan (located on the last few pages of this packet). I understand that all patients must abide by these policies and that if I have any questions about them I can ask the office staff for clarification.

Patient Signature: ____ Date: _________________

Medications List:

☐ Please check this box if you are not currently on any medications.

☐ Please check this box if you did not bring your medication bottles or list and will need to call the office after your appointment to provide this information.

☐ If you have a written or typed list of your medications, please attach a copy to this paperwork instead of writing them out below (we can make a photocopy if needed).

Otherwise please fill in the following information regarding your medications:

	Name:	Dosage (mg):	# of Pills:	When taken:	Prescribed by:
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

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HIPAA Privacy Authorization Form

Authorization for use or disclosure of Protected Health Information required by the Health Insurance Portability and Accountability Act - 45 CFR Parts 160 and 164

Please list any individuals (including family members and spouses) that we may discuss/release your protected health information to (including upcoming appointments, treatment, billing, surgical procedures, condition, and prognosis).

Name: ________________________________ Name: ________________________________

Relationship: ___________________________ Relationship: ___________________________

Phone #: ______________________________ Phone #: ______________________________

☐ Please check this box if you **do not** want any information regarding your treatment at our office to be shared with anyone (including family members and spouses).

Messaging and Appointment Reminders per the Telephone Consumer Protection Act (TCPA)

Let us know if we can send messages about your protected health information (including reminders for upcoming appointments) by:

Phone call/voicemail? ☐ Yes ☐ No

Email? ☐ Yes ☐ No

Text? ☐ Yes ☐ No

This authorization will be in effect for all past, present, and future dates (up to 9 months after the patient's death) unless a preferred expiration date is specified here: _____________________.

If you would like to make any changes to this authorization, please notify our office so that a new HIPAA form can be completed and added to your file.

Patient Name (please print): ____

Patient Signature: ____ Date: _________________

Staff Signature: ____ Date: ________________

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Financial Policies for Patients of Dr. W. Clark Jernigan

Dr. W. Clark Jernigan is only in network with traditional Medicare plans and does not accept payment from most insurance companies.

For patients who have traditional Medicare with or without a supplement policy:

Although most of our patients do not have this issue, Dr. Jernigan's office cannot guarantee that my supplement insurance plan will fully cover the remaining costs of my visit.

I know that I can contact my insurance plan to inquire what services they will and will not cover.

For patients who do not have traditional Medicare and will be self-pay:

I am responsible for filing my claim with my insurance company for out of network benefits.

The amount my insurance will reimburse is between me and my insurance company, and it is not guaranteed that this will be equal to the amount I paid to Foothills Orthopaedics.

I will need to contact my insurance about what is required to submit a claim.

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Controlled Substance Policy

If your provider at Foothills Orthopaedics & Sports Medicine Center determines that it is **medically necessary** to have your pain managed with narcotic pain medications, all patients must adhere to the following guidelines:

1. These medications may cause physical dependence and addiction. The use of these medications in ways other than prescribed may result in adverse effects of an unforeseen nature. They are also highly regulated by the Drug Enforcement Agency (DEA). It is mandatory that you adhere to the prescribed treatment plan in order for your provider to prescribe these medications safely.
2. Take your medications only as directed. For any changes in dose or frequency, you must see your provider at Foothills Orthopaedics.
3. Only take controlled substances that are prescribed by your provider at Foothills Orthopaedics.
4. If any other provider you are seeing prescribes you other controlled substances, you must inform your provider at Foothills Orthopaedics immediately.
5. Your provider will not prescribe narcotic medications to you for an extended length of time. You will not receive over ninety (90) tablets of narcotic medication per month, and you will only receive three (3) refills of these medications with your prescription per your provider’s discretion.
6. Narcotic prescriptions can no longer be called into the pharmacy. These prescriptions must be picked up in person from our office during business hours. The individual picking up the prescriptions must present photo identification and sign for the prescriptions.
7. You will not receive replacements for lost or stolen medications. It is your responsibility to make sure your amount dispensed from the pharmacy is correct.
8. You must abstain from alcohol or any other mood-altering substances not prescribed by a physician while on the controlled substance. These medications can interact with alcohol in negative and extremely hazardous ways.
9. You must agree to provide random urine and/or blood drug screens at any time as requested by your provider at Foothills Orthopaedics.
10. You must agree to accept referral for addiction evaluation if and when your provider feels it is appropriate.
11. Failure to adhere to any part of this agreement will result in discontinuation of treatment at Foothills Orthopaedics & Sports Medicine Center