Dr. Nicholas E. Mihelic

PATIENT INFORMATION RECORD

Name______________________SSN_________________ DOB__________________
Address:____
City:______________________State:________________Zip____________________
Home Phone:__________________ Cell:_____________Work:__________________
Marital Status:__________Spouse's Name___________________________________
Emergency Contact:____
Allergies:____

Employment Information

Name of Employer:____
Employer Address:____
Employer Phone Number:____
Employer Fax Number:____
Are you retired?_____________________ Full-Time Student__________________

Insured

Name of Policy Holder:___________________________SSN:___________________
Relationship to Insured:_________________Address:_________________________

Medical Information

Reason for Visit:____
Date of Injury:_____________Type of Injury: Auto____Work_____Sports____
How long have you had this problem:______________________________________
Were you seen in the ER?________________ Second Opinion?_______________
Are you pregnant or do you think you might be pregnant?_________________
Who referred you to our office?____

Payment is due when services are rendered. We do not file secondary insurances. Nicholas E. Mihelic, M.D. , is in no way responsible for knowing your insurance type or policy coverage. It is up to patient to determine in network providers for their individual policies. As a courtesy, we will file primary insurances. Please remember insurance coverage is a contract between the patient and the insurance company. We do not accept reasonable and customary charges from insurance companies we are not contracted with. Please have your insurance cards available at check-in for every office visit.

I authorize Nicholas E. Mihelic, M.D., perform treatment deemed by the physician in exercise of professional judgment to be of appropriate kind and method on me/my dependent. I hereby authorize, Nicholas E. Mihelic, MD to release my information acquired in my examination or any insurer, government agency providing benefits, or to anyone for charges. I hereby assign to and authorize Nicholas E. Mihelic, MD, benefits payable, Workers Compensation and/or liability claims may not pay all of my/my dependents bill. I agree to pay the difference or the entire bill if necessary. I also agree to pay costs of collection, including Attorney's fees and waive my exemption under the constitution and laws of the State of South Carolina.

PATIENT/GUARANTOR:
(Print)____
Signature:__________________________________DATE:________________________

Dr. Nicholas E. Mihelic, PA
Moss Creek Sport and Spine Institute
15 Moss Creek Village
Hilton Head, SC 29926

Dear Patient:

We are required by law to maintain the privacy of each of our patients, in order to assist you and your family in accessing your personal medical inforamtion. Please take a moment to read and complete the following information which will be kept in your permanent medical chart and can only be revoked or changed by you, the patient or the legal guardian of the patient, if applicable.

Will you authorize your spouse or domestic partner access to your medical records? This may include possible discussion of your current health information without your presence or knowledge by way of verbal discussion, written or faxed correspondence.

Please mark the appropriate box: YES_____________NO__________________

Would you like to authorize one (1) additional person to access your medical records? Child, Attorney, Primary Care Physician, etc? This will help us ensure an unauthorized will not gain access to your records.

Please mark the appropriate box:YES______________NO__________________

Please List the Family Members, if any, whom we may inform about your medical condition ONLY in a MEDICAL EMERGENCY:

Name______________________________Relationship_____________________

Date:____________ Patient Signature:_____________________________

MEDICAL HISTORY QUESTIONNAIRE

Patient Name:____
Date of Birth:______________**Age:**_________**Sex:**___________________

Who REFERRED you to our office?________________________________

Past Medical History

Do you have, or have you EVER had, any of the following? **Please circle**

Diabetes	**Hypertention**	**Heart Condition**	**Seizures**	**Ulcers**
Blood Disorder	**Blood Clots**	**Sleep Apnea**	**Stroke**	**Asthma**
Emphysema	**Kidney Stones**	**Complications from Anesthesia**		**Cancer**

List other medical conditions and/or illnesses not mentioned above:____
____
____
____
____

List any hospitalizations and/or surgeries with dates and any complications:____
____
____
____

List Current Medications (to include RX and Over the counter drugs/health/herbal drugs)____
____
____
____
____
____
____

List any allergies:____
____
____
____

List any significant injuries you have sustained:______________________________

Age and Overall Health of Parents (if Deceased please provide age and cause)______________________________

Age, Sex and Health of Siblings:(if Deceased please provide age and cause)______________________________

Please list any significant family health problems:______________________________

Marital Status:______________**Education**:(Years/Degree)______________________
Alcohol use (type/amount):_________________**Tobacco Use** (amt/yrs)____________
Employer:____________________**Occupation**:_______________________________

Were you injured on the job?_________Is there/will there be litigation?____________
Date of Injury/if any:__________________________

REVIEW of SYMPTOMS:(Circle positive symptoms and describe and /or add others:)
Constitutional: Fever, weight gain/loss, loss of appetite:________________________________

Eyes: Double Vision, blurring,difficulty seeing:______________________________________

ENT: Deafness, sinusitis, hoarseness,vertigo:____

Cardiovascular: Chest Patin, palpitations,irregular/rapid heartbeats, murmur___________________

Respiratory: Shortness of Breath, wheezing, blood, chronic cough:__________________________

Digestive:Abdominal pain, constipation, diarrhea, bleeding:______________________________

Urologic:Pain when urinating, hesitancy, bleeding,incontinence:___________________________

Gynecologic: Breast masses, pain, discharge:____
What was the date of your last exam:______________________________
What was the date of your last pap smear:___________________________

Skin: Rashes, lesions that do not heal, changes in moles:_____________________________

Neurologic:Seizures, loss of balance/coordination, paralysis, weakness/loss of memory:____

Psychiatric:Depression, anxiety, hallucinations, sleep disturbances:__________________________

Endocrine:Excessive thirst,excessive urination,heat/cold intolerance:_________________________

Blood and Lymph:Anemia, bleeding tendancies,swollen nodes:____________________________

Allergic and Immunologic: Hives, eczema, itching:______________________________________

Musculoskeletal: Stiffness,joint pain/deformity, muscle wasting, spine pain radiating to arm/leg:_____
____
____

OTHER:____

Patient Signature:______________________________**Date:**___________________________

ABN
Advance Beneficiary Notice
for Injectables
Celestone, Lidocaine and Marcaine

Our Orthopaedic practice will be charging $35.00 for each injection of above injectables that you may receive, when necessary, in our office.

The reason for the charge is that the above medications are reimbursed by insurance companies below our cost to purchase. In addition, the local anesthetic medication has never been covered by insurance.

In compliance with Medicare and other insurance company guidelines, we cannot submit these charges to your insurance company. However, we will give you a HCFA1500 form to submit to your insurance company.

If the Doctor ever suggests than an injection may help your condition, you have a choice.

1. You can choose to have an injection and agree to pay at time of service.

2. You can refuse to have an injection.

I agree to pay for an injection, should I receive one.

YES_________________ NO___________________

Patient Signature____

Date___________________