**Gavin**
**Orthopaedics, LLC**

MOSS CREEK ORTHOPAEDIC URGENT CARE
Scrapes • Sprains • Shots • Stitches

OKATIE•RIVERWALK ORTHOPAEDIC URGENT CARE
Scrapes • Sprains • Shots • Stitches

# Initial Visit Knee

Date:_____

Age:_____

Patient Name: _____

Date of Birth _____

Referring Physician: _____ Primary Physician _____

Problem with: ☐ **RIGHT** KNEE ☐ **LEFT** KNEE Estimated date first noticed problems: _____/_____/_____

Was this due to injury? ☐ Yes ☐ No Was injury work related? ☐ Yes ☐ No

Currently working? ☐ Yes ☐ No How did injury occur :_____

Prior Knee Surgery? ☐ Yes ☐ No If yes, list date, procedure and doctor _____

How would you rate your worst pain? ☐ 1 (No pain), ☐ 2, ☐ 3, ☐ 4, ☐ 5, ☐ 6, ☐ 7, ☐ 8, ☐ 9 and ☐ 10 (severe pain)

Problem is presently: ☐ Worsening ☐ Unchanged ☐ Improving

The pain is? ☐ Constant ☐ Intermittent

Location? ☐ Medial (inner thigh) ☐ Lateral (outer side) ☐ Anterior (front)
☐ Diffuse (all over) ☐ Posterior (back)

Quality? ☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing
☐ Tingling ☐ Electric Shocks

Other Complaints? ☐ Locking ☐ Giving way ☐ Night Pain ☐ Pain with stairs ☐ Stiffness
☐ Grinding/Popping ☐ Swelling ☐ Weakness ☐ Other_____

**Activities which were interfered with include:**

☐ Sports ☐ Walking ☐ Shopping ☐ Stair Climbing ☐ Kneeling ☐ Squatting ☐ Running
☐ Sleeping ☐ Gardening ☐ Working ☐ During Exercise ☐ After Exercise ☐ Rising from a chair
☐ Other_____

**Treatments that have been tried include:**

| | | | | | | |
|---|---|---|---|---|---|---|
| ☐ Anti Inflammatory_____ | ☐ Helped? | ☐ Not Helped | ☐ Physical Therapy | ☐ Helped? | ☐ Not Helped |
| ☐ Pain Medications _____ | ☐ Helped? | ☐ Not Helped | ☐ Crutches/Cane/Walker | ☐ Helped? | ☐ Not Helped |
| ☐ Exercises | ☐ Helped? | ☐ Not Helped | ☐ Bracing | ☐ Helped? | ☐ Not Helped |
| ☐ Reduced Activity | ☐ Helped? | ☐ Not Helped | ☐ Knee Injection | ☐ Helped? | ☐ Not Helped |
| ☐ Knee Drained | ☐ Helped? | ☐ Not Helped | ☐ MRI | ☐ Other_____ | |

**Review of Systems: Please check all that apply for you**

| | | | |
|---|---|---|---|
| ☐ Chest Pain | ☐ Hypertension | ☐ Parkinson's Disease | ☐ Sickle Cell Disease |
| ☐ Heart Murmer | ☐ Leukemia | ☐ Liver Disease | ☐ Thalassemia/Von Willebrands |
| ☐ Heart Attack | ☐ Emphysema/Chronic Bronchi | ☐ Hearing Loss | ☐ Hemophilia |
| ☐ Heart Valve Disease | ☐ Kidney Failure | ☐ Poor Vision | ☐ Stomach Ulcer/Reflux |
| ☐ Irregular Heart Beat | ☐ Kidney Stones | ☐ Cataracts | ☐ Ulcerative Colitis/Chron's |
| ☐ Pacemaker | ☐ Prostate Disease | ☐ Depression/Bipolar Disorder | ☐ Hepatitis |
| ☐ Stroke | ☐ Incontinence | ☐ Schizophrenia | ☐ Psoriasis or Skin Disease |
| ☐ TIA | ☐ Seizure | ☐ Thyroid Disease | ☐ HIV |
| ☐ Asthma/Tuberculosis | ☐ Multiple Sclerosis | ☐ Adrenal/Pituitary Disease | ☐ COPD |

☐☐ Cancer, which type/where?_____ Treatment_____

☐☐ Diabetes, controlled with: Insulin Oral Medication Diet

☐☐ None of the above _____ ☐☐ Other_____

☐☐ **SECOND OPINION**_____

| Family History | Yes? | Relationship | Family History | Yes? | Relationship |
|---|---|---|---|---|---|
| Arthritis (Specify type) | | | High Blood Pressure | | |
| Bleeding Problems | | | Congenital Heart Disease | | |
| Cancer (Specify) | | | Leukemia | | |
| Diabetes | | | Liver Disease | | |
| Emotional Problems | | | Stroke | | |
| Epilepsy/Seizures | | | Suicide | | |
| Heart Disease | | | Tuberculosis | | |

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## Initial Visit Sheet

**Name:** _____ **Date:** _____

**Date of Birth:** _____

**Allergies:** **Reactions:**

_____

_____

_____

**Current Medications:**

**Medication:** **Dose:** **Reason for Medication:**

_____

_____

_____

_____

**Past Medical Problems: ✓ Items if Yes and Explain**

| | | | |
|---|---|---|---|
| Alcoholism | ☐ _____ | Heart Disease (specify) | ☐ _____ |
| Arthritis (Specify Type) | ☐ _____ | High Blood Pressure | ☐ _____ |
| Asthma | ☐ _____ | Hepatitis (type) | ☐ _____ |
| Anemia | ☐ _____ | HIV/AIDS | ☐ _____ |
| Blood/Bleeding Problems | ☐ _____ | Kidney Problems | ☐ _____ |
| Cancer | ☐ _____ | Osteoporosis | ☐ _____ |
| Chronic Lung Disease | ☐ _____ | Polio | ☐ _____ |
| Cirrhosis of Liver | ☐ _____ | Prostate Problems | ☐ _____ |
| Colon or Bowel Trouble | ☐ _____ | Stroke/TIA | ☐ _____ |
| Convulsions/Seizures | ☐ _____ | Stomach or Duodenal Ulcer | ☐ _____ |
| Deafness/Hard of Hearing | ☐ _____ | Sexually Transmitted Disease | ☐ _____ |
| Diabetes | ☐ _____ | Skin Disease | ☐ _____ |
| Emotional Problems | ☐ _____ | Tuberculosis | ☐ _____ |
| Glaucoma | ☐ _____ | Thyroid Problems (specify) | ☐ _____ |
| Gout | ☐ _____ | Varicose Veins | ☐ _____ |

**Surgeries:** **Other Surgeries:**

| | | | |
|---|---|---|---|
| Tonsillectomy | ☐ ____/____/____ | _____ | ☐ ____/____/____ |
| Appendectomy | ☐ ____/____/____ | _____ | ☐ ____/____/____ |
| Hernia Repair | ☐ ____/____/____ | _____ | ☐ ____/____/____ |
| Gall Bladder | ☐ ____/____/____ | _____ | ☐ ____/____/____ |
| Hysterectomy | ☐ ____/____/____ | _____ | ☐ ____/____/____ |

**Social History:**

Marital Status ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Do you drink alcohol? ☐ Never ☐ Socially ☐ Rarely ☐ Moderately ☐ Heavily ☐ Recovering Alcoholic

Do you smoke? ☐ Never ☐ Yes Amount? _____ ☐ Former Smoker – Quit When? _____

Height: Feet: _____ Inches: _____ Weight: _____ Recent Gain or Loss – Amount _____

Current Job Description: _____ Duties: _____

Do you live in (CIRCLE) One story Home Apartment Two story Home

Do you have bathroom facilities on the first floor? ☐ Yes ☐ No

_____ _____ _____

Patient Signature Date Physician Signature

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OKATIE•RIVERWALK ORTHOPAEDIC URGENT CARE

MCOUC & OKUC are locations under the umbrella of Gavin Orthopaedics, LLC. We do not file insurance as urgent care, but rather office visits that offer walk-in convenience.

# WELCOME TO OUR OFFICE!

☐ **Patient is a Minor**

○ **Moss Creek** ○ **Okatie** ○ **Gavin**

Date_____

Last Name _____ First_____ Middle_____

Address _____Plantation_____

City_____ State_____ Zip_____ Home Phone_____

**SSN** _____ Date of Birth_____ Age_____ M/F_____

** It is our office policy you provide at least the last 4.

E-mail Address _____ Cell Phone_____

## Emergency Contact Information

Name _____ Relationship_____

Address _____ Employer_____

Home Phone _____Cell Phone_____ Work Phone_____

How did you learn about our practice? _____

Has Dr. Gavin treated any of your family members before? _____

If so, who? _____ Referring Physician_____

## INSURANCE POLICY INFORMATION

PLEASE HAVE YOUR ID CARDS READY

Primary Insurance _____

Policy Number _____

Secondary Insurance _____

Policy Number _____

## Responsible Party Information (Insurance Policy Holder/ MINOR GUARDIAN)

Name _____ Relationship_____

Address _____ Employer_____

Home Phone _____Cell Phone_____ Work Phone_____

**SSN** _____ Date of Birth _____

** It is our office policy you provide at least the last 4.

## Is this visit related to an accident?

**Motor Vehicle Accident? Y / N** **Workers Compensation? Y / N** **Other? Y / N**

***See front desk for additional paperwork regarding accident***

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Responsibilities of the office:

**The office will make a good effort to obtain necessary pre-certifications for requested procedures required by contracted third parties to facilitate approval for payment. Failure to obtain pre-certifications or approval from the insurance company does not necessarily mean that the requested procedure is not medically necessary; in this circumstance, the patient will be financially responsible for services ordered or rendered.**

Upon receiving accurate insurance/third party information the clinic will file an appropriate American Medical Association-approved claim to the appropriate entity. The office will make a good-faith effort with help from the patient to follow up these claims to facilitate payment.

It is expected that any copay/deductible due will be collected AT TIME OF SERVICE.

IF YOU DO NOT HAVE INSURANCE YOUR PAYMENT IS DUE IN FULL AT TIME OF SERVICE.

As a courtesy, Gavin Orthopaedic, LLC verified your benefits with your insurance company. If you were quoted an amount that is different from your balance, remember it was a quote and we do not know the actual balance until your claim has processed.

There is not a guarantee of benefits or payment. Your claim processed according to your plan, if your claim processes differently from the quote you are still responsible for the amount that your insurance has deemed your responsibility.
We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of their visit, but sometimes there is a balance after the insurance has paid and this is patients' responsibility to pay the remaining amount.

Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physicians' referral and our verification of your insurance benefits are not a guarantee of payment.

We highly recommend you also contact your insurance carrier and check into your coverage for Orthopaedic specialty. Do not assume that you will not owe anything if you have more than one insurance company.

I state that I have read this financial policy and procedure and have been given an

opportunity to ask questions. I state that I have read and received the Notice of Privacy Practices regarding my healthcare and HIPAA. I accept this policy and procedure and will comply with it as part of my professional relationship with Dr. Gavinâ€™s offices.

Patient or Responsible Party

Printed Name: _____

Signature : _____

Date: _____

If patient is a Minor - Relationship to Patient: _____

OKATIE•RIVERWALK ORTHOPAEDIC URGENT CARE
Gavin Orthopaedics, LLC
MOSS CREEK ORTHOPAEDIC URGENT CARE

15 Moss Creek Village ◆ Hilton Head Island, SC 29926
147 Riverwalk Blvd Unit 3&4 • Ridgeland, SC 29936
Gavin Office: 843-681-5077 ◆ Fax: 843-681-5012
Okatie Office 843-645-2669 • Okatie Fax 866-788-7789
Moss Creek Office 843-836-7022 • Moss Creek FAX 843-836-3056

# HIPAA PERMISSIONS

**Please keep in mind, we confirm all appointments 2 -3 days in advance, if we cannot contact you or you do not call back to confirm your appointment, it will be canceled.**

**What method can we use to contact you about your appointments?**

☐ Phone: Preferred Number_____ Text ☐ Call ☐

☐ Email _____

**May we leave messages on your voicemail with your specific appointment information?**

☐ Yes ☐ No

**May we release your complete medical records to your referring physician and/or your primary care physician?**

☐ Yes ☐ No

**I, the patient hereby authorizes J. Robert Gavin, Jr. and all Physicians Assistants to release my medical information (appointments, lab/x-ray results, diagnoses. Treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:**

| Name | Date of Birth | Relationship | Phone# |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**I further release my medical information to the following physicians, clinics, and/or hospitals:**

| Doctor | Phone # | Clinic |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Patient Name (Printed):** _____

**Patient /Guardian Signature:** _____ **Date:** _____