303 East Wood Street
Spartanburg, SC 29303

Orthopedic Specialties
of Spartanburg

Phone (864) 208-8800
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Section I Patient Information

Name ______________________ Birth Date __________ SS# ______________

Street Address ______________________ What is your preferred Language? __________

Mailing Address ______________________

City/State/Zip ______________________

Home Phone ______________ Cell Ph# ______________ Work Ph# ______________

Email ______________________ Employer ______________________

Please check approved methods of contact: ☐ Phone/Voicemail ☐ Web Portal ☐ Email Which is your preferred method of contact: __________

Employer's Address ______________________

City, State, Zip ______________________

Nursing Home: ☐ YES ☐ NO Nursing Home Name/Ph.# ______________________

Section II Responsible Party (Fill out this section if the patient is a minor or has a legal guardian)

Responsible Party Name ______________________ SS# ______________

Relationship to Patient ______________________ Employer ______________

Address ______________________ City/State/Zip ______________

Home Phone ______________________ Work Phone ______________

Section III Emergency Contact (Please give someone outside your immediate family)

Contact Name ______________________ Relationship __________ Phone __________

Address ______________________ City/State/Zip ______________

Section IV Insurance Information (YOU MUST FURNISH COPIES OF ALL INSURANCE CARDS)

Primary Insurance Information

Insurance Co. Name

Relationship of Pt. to Insured (Circle One) **Spouse** **Child** **Other**

Insured Name

Policy/I.D # - Group #

Insured SS#

Insured Birth Date

Insured Employer

Secondary Insurance Information

Insurance Co. Name

Relationship of Pt. to Insured (Circle One) **Spouse** **Child** **Other**

Insured Name

Policy/I.D # - Group #

Insured SS#

Insured Birth Date

Insured Employer

Insurance Authorization and Assignment

I hereby authorize Orthopedic Specialties of Spartanburg, LLC to furnish information to insurance carriers and referring physicians concerning my illness and treatment, and I hereby assign to the physicians all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I certify that all information provided here is correct to the best of my knowledge.

Date ______________ **Signature of Patient** **X** ______________________

PATIENT HISTORY

Patient Name ____________________ Date of Birth ____________ Age ________

Reason for Visit: ____

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ACCIDENT DETAILS

Was this an accident: Yes ❑ Date of Accident ____________________ No ❑ Skip to Non-Accident Details below.

Type of Accident: Work ❑ Employer ______________________________ Home ❑ Auto ❑

If Auto, were seat belts worn? ❑ Yes ❑ No Were you the driver? ❑ Passenger? ❑

Sport - School Name ____________________ Which Sport ____________ ❑Other ____________

How did accident happen: ____

Where did accident happen: ____

Do you have an attorney: Yes ❑ No ❑ If yes, Attorney Name ____________________

NON ACCIDENT DETAILS

How/When/Why did problem start: ____

Was onset: Gradual ❑ Sudden ❑ Is Problem: Constant ❑ Intermittent ❑

Have you been treated for the same / similar problem? Yes ❑ By whom ____________________ No ❑

Were you seen in the ER or Urgent Care? Yes ❑ Where ____________________ No ❑

Have you had X-rays for this problem? Yes ❑ Where ____________________ When ____________ No ❑

Have you had an MRI for this problem? Yes ❑ Where ____________________ When ____________ No ❑

Are you out of work due to this problem: Yes ❑ Last Date Worked ____________________ No ❑

What medications have you taken or been prescribed specifically for this problem: ____________________