Premier ORTHOPAEDICS

Today's Date: _____

Name:_____ DOB:_____ SS#_____

Address:_____ Apt#_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ E-Mail:_____

*Race:_____ *Ethnicity:_____ *(*required by Medicare)* Gender: _____

Primary Care Physician: _____ Who Referred you: _____

Primary Care Physician Address:_____

How did you hear about our practice? _____

Pharmacy Name and Phone: _____

PLEASE GIVE ALL INSURANCE CARDS TO THE FRONT DESK

Primary Insurance

Type of Coverage: [ ] Health [ ] Workers Comp [ ] Auto Accident [ ] Slip & Fall

Date of Injury / Accident: _____

Insurance Company Name/Address/ Zip/Phone: _____

_____

I.D./Claim Number _____ Group Number: _____

Adjustor Name: _____ Adjustor Phone # _____

Policyholder Name: _____ [ ] Self [ ] Spouse [ ] Parent [ ] Other

Policyholder Address: (if different than patient) _____

Policyholder S.S. # _____ Policyholder Date of Birth: _____

Secondary Insurance

Insurance Company
Name/Address/Zip/Phone:_____

_____

I.D. Number: _____ Group Number: _____

Policyholder: _____ [ ] Self [ ] Spouse [ ] Parent [ ] Other

Policyholder S.S. # _____ Policyholder Date of Birth: _____

Is patient responsible for bills? _____YES _____NO If **NO**, please provide the following:

Name of responsible party: _____ Date of Birth: _____

Address: _____

City, State, Zip Code: _____ Social Security #: _____

Relationship to patient: _____ Phone #: _____

MEDICAL HISTORY FORM (please complete in BLACK ink)

HISTORY OF PRESENT ILLNESS/INJURY

Body Part(s): _____ □ Right □ Left □ Bilateral (both sides)

Onset/Date of Injury: _____ Height: _____ Weight: _____

Did this occur suddenly or gradually? _____

Complaint: □ Pain □ Numbness □ Swelling □ Weakness □ Other: _____

Severity:
□ Mild
□ Mild/Moderate
□ Moderate
□ Moderate/Severe
□ Severe

Status:
□ Unchanged
□ Better
□ Fluctuating
□ Improving
□ Worse
□ Resolved

Frequency:
□ Intermittent
□ Occasional
□ Constant
□ Rare

Quality:
□ Aching
□ Burning
□ Dull
□ Sharp
□ Throbbing

Context: □ Injury □ Sports Injury □ MVA □ Work Injury □ Other _____

Are you experiencing radiating pain? □ Yes □ No If "yes", where does the pain radiate to: _____

Aggravated by:
□ Bending
□ Climbing Stairs
□ Descending Stairs
□ Lifting
□ Movement
□ Pushing
□ Sitting
□ Standing
□ Walking
□ Other: _____

Relieved by:
□ Brace/Splint
□ Elevation
□ Exercise
□ Heat
□ Ice
□ Injection
□ Massage
□ Pain/Rx Meds: _____
□ Mobility
□ OTC Meds: _____
□ PT
□ Rest
□ Stretching
□ Other: _____

Associated Symptoms/Pertinent Negatives:
□ Bruising
□ Crepitus (cracking sounds)
□ Decreased Mobility
□ Difficulty going to sleep
□ Instability
□ Limping
□ Locking
□ Night Pain
□ Night-time awakening
□ Numbness
□ Popping
□ Spasms
□ Swelling
□ Tingling in the arms
□ Tingling in the legs
□ Tenderness
□ Weakness
□ Other _____

Have you had similar symptoms before? □ Yes □ No If "yes", when _____

Doctors who have treated you for this problem: _____

Did that doctor refer you here? □ Yes □ No

Please list all diagnostic tests and treatment performed elsewhere for today's problem (please provide When/Where/What):
_____

_____

REVIEW OF SYSTEMS (Do you have any of the following symptoms? (Please check all that apply.)

Constitutional:
□ Fatigue
□ Fever

Metabolic/Endocrine:
□ Cold Intolerant
□ Heat Intolerant

Neurological:
□ Seizure
□ Dizziness
□ Poor Coordination

Immunological:
□Environment Allergies
□ Food Allergies

HEENT:
□ Headache
□ Vision Loss

Hematologic/Blood:
□ Bleeding

Respiratory:
□ Cough
□ Dyspnea (shortness of breath)

Cardiovascular:
□ Chest Pain
□ Cyanosis (blue coloration of skin)
□ Irregular Heartbeats/Palpitations

Integumentary/Skin:
□ Rash
□ Lesion/Wound

Gastrointestinal:
□ Constipation
□ Diarrhea

Genitourinary:
□ Dysuria (painful urination)
□ Hematuria (blood in the urine)
□ Nausea
□ Vomiting

□ **NONE**

Current Medications: □ **NONE** □ **List attached**
_____
_____
_____

Allergies/Reactions: □ **NONE**
_____ / _____
_____ / _____
_____ / _____

Do you have a history of infection with a bacteria called MRSA? □ Yes □ No Date treated: _____

PATIENT'S MEDICAL HISTORY (Please check all that apply)

□ AIDS/HIV
□ Alcoholism
□ Alzheimers
□Anemia
□ Angina
□ Arthritis
□ Asthma
□ Atrial Fibrillation
□ Benign Prostatic Hypertrophy
□ Cancer
□ Cerebrovascular Accident (Stroke)
□ Congestive Heart Failure (CHF)
□ COPD (Emphysema)
□ Coronary Artery Disease
□ Crohn's Disease
□ Degenerative Joint Disease
□ Depression
□ Diabetes
□ Drug Abuse
□ DVT (Blood Clot)
□ Fibromyalgia
□ Gallbladder Disease
□ GERD
□ Gout
□ Hepatitis
□ Hyperlipidemia
□ Hypertension
□ Inflammatory Bowel Disease
□ Juvenile Rheumatoid Arthritis
□Kidney Disease
□Liver Disease
□ Lyme Disease
□ Migraine Headaches
□ Multiple Sclerosis
□ Myocardial Infarction (heart attack)
□ Obesity
□ Osteoarthritis
□ Osteoporosis
□ Parkinson Disease
□ Peptic Ulcer Disease
□ Psoriasis
□ PVD
□ Renal Disease
□ Rheumatoid Arthritis
□ Scoliosis
□ Seizure Disorder
□ Sleep Apnea
□ SLE (Lupus)
□ Spinal Stenosis
□ Thyroid Disease
□ Valvular Disease
□ **None**
□ **Other**:

PAST SURGICAL HISTORY □ **No Prior Surgery**

Operation (please verify what side of the body when necessary)	**DATE**

PATIENT'S FAMILY HISTORY

Heart Disease □ Yes □ No **Cancer** □ Yes □ No **Diabetes** □ Yes □ No
Rheumatologic/Gout Disorders □ Yes □ No **Bleeding Disorders** □ Yes □ No **History of Blood Clots** □ Yes □ No
Family history of chronic/inherited diseases:_____
Is your father living □ Yes □ No | **Is your mother living** □ Yes □ No
If no, cause of death(s) : _____

PATIENT'S SOCIAL HISTORY

Tobacco Use: □ Yes □ No □ Former/Year Quit _____ **Consume Alcohol:** □ Yes □ No □ Former/Year Quit _____
Substance Abuse: □ Yes □ No □ Former/Year Quit _____
Activity Level: □ Sedentary □ Moderate □ Vigorous **Type of Exercise**: _____
Occupation: _____ **Employment Status**: □ Full Time □ Part Time □ Unemployed □ Unable to work □ Light Duty

Date: _____ **Signature of Patient, Parent, or Guardian:** _____

Date: _____ **Reviewing Physician Signature:** _____

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I acknowledge that I have been offered the "Notice of Privacy Practices for Premier Orthopaedic and Sports Medicine Associates, LTD. and that I authorize the use and disclosure of health information about

(patient's name) _____ for treatment, payment, and healthcare operations purposes consistent with its "Notice of Privacy Practices."

_____ _____

Signature of Patient/Representative Date

Authorization for Consent for Treatment and Release of Information and Direct Payment to the Doctor

DIRECT PAYMENT: I authorize and direct my Insurance Carrier(s) to make payments for medical or surgical treatment, injections, supplies, and x-rays directly to Premier Orthopaedic and Sports Medicine Associates, LTD. I hereby authorize the submission of all information necessary to complete this claim. These authorizations shall be effective for me and my dependents. I agree that a copy of this authorization shall be valid as the original.

MEDICARE and MEDIGAP: I request that payment of authorized MEDICARE and MEDIGAP benefits be made either to me or on my behalf to the treating physician for services furnished by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents to my MEDIGAP insurer and any information needed to determine these benefits or the benefits payable for the related services.

I understand and agree that I am responsible for payment of all charges not fully paid by my insurance.

I hereby authorize the physician(s) of Premier or their designee(s) to provide Medical Evaluation and/or Treatment to me.

_____ _____

Signature of Patient/Representative Date

Information Disclosures to Individuals Involved in Patient's Care (HIPAA)

I authorize Premier Orthopaedic and Sports Medicine Associates, LTD. to disclose my health information that is directly related to my current treatment to the individuals listed below for purposes of their role in my treatment or payment for the health services that I have received.

NAMES OF INDIVIDUALS RELATIONSHIP TO PATIENT

_____ _____

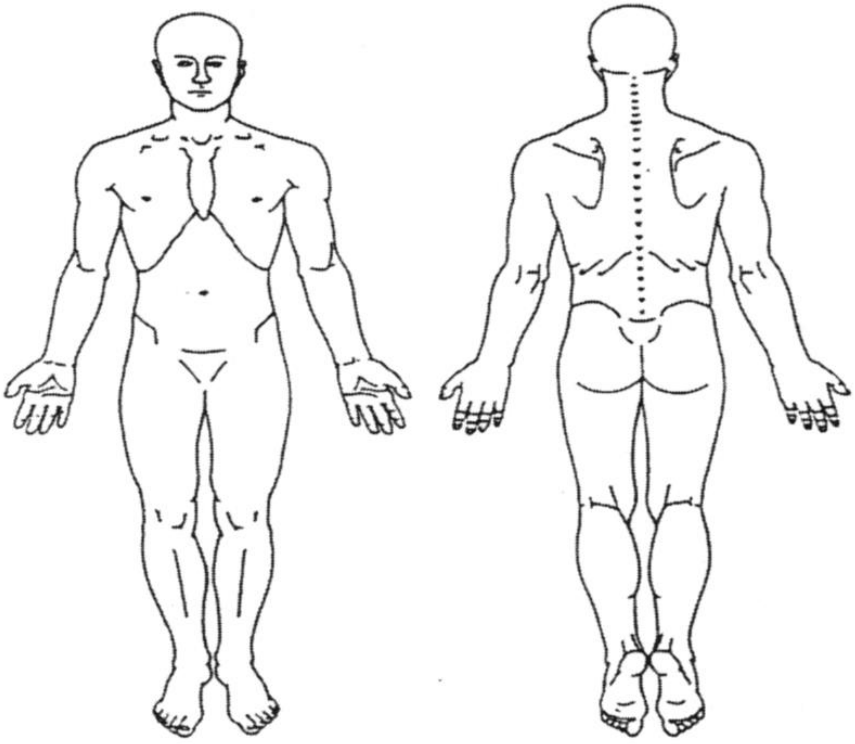
_____ _____

_____ _____

Authorization to leave answering machine/voicemail messages □ **YES** □ **NO**

Premier ORTHOPAEDICS

On the **Body Diagram** below, please indicate where your pain is located **at the present time**. Use key to the right



XXXXX	PAIN
OOOO	NUMBNESS
////////	ACHING
******	PINS/NEEDLES

Location	Pain %
Back	
Leg/Buttock	
Neck	
Arm (s)	