

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: _____

Preferred Language: _____

Primary Care Physician: _____ Who Referred you: _____

Primary Care Physician Address: _____

How did you hear about our practice? _____

Pharmacy Name and Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

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

Name: _____ DOB: _____ Age: _____ Date: _____

Referred by: _____ Onset/Date of Injury: _____

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

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:
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Fever | Metabolic/Endocrine:
<input type="checkbox"/> Cold Intolerant
<input type="checkbox"/> Heat Intolerant | Neurological:
<input type="checkbox"/> Seizure
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Poor Coordination | Immunological:
<input type="checkbox"/> Environment Allergies
<input type="checkbox"/> Food Allergies | HEENT:
<input type="checkbox"/> Headache
<input type="checkbox"/> Vision Loss |
| Hematologic/Blood:
<input type="checkbox"/> Bleeding | Respiratory:
<input type="checkbox"/> Cough
<input type="checkbox"/> Dyspnea (shortness of breath) | Cardiovascular:
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Cyanosis (blue coloration of skin)
<input type="checkbox"/> Irregular Heartbeats/Palpitations | Integumentary/Skin:
<input type="checkbox"/> Rash
<input type="checkbox"/> Lesion/Wound | |
| Gastrointestinal:
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting | Genitourinary:
<input type="checkbox"/> Dysuria (painful urination)
<input type="checkbox"/> Hematuria (blood in the urine) | <input type="checkbox"/> None of the above | | |

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)

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

CONSENT TO RECEIVE ELECTRONIC AND OTHER COMMUNICATIONS

I hereby agree to receive communications from, or on behalf of, Premier Orthopaedic and Sports Medicine Associates, Ltd. (collectively, "Premier"), including, without limitation, automated, autodialed, and prerecorded communications, either by text message, phone call, or e-mail, at the phone number and e-mail address provided. I understand that this consent is not a condition to my receiving services from Premier. I also understand that I can revoke this consent at any time by providing reasonable notice of such revocation to Premier.

Signature of Patient/Representative

Date