**ORTHOPAEDIC KNEE SHOULDER & SPORTS SURGERY**

**REGISTRATION FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Today’s date:** | | | | | | | | | | **PCP:** | | | | | | | | | | | |
| **PATIENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | |
| **Patient’s last name: First: Middle:** | | | | | | | | | | | **Mr.**  **Mrs.** | | **Miss**  **Ms.** | | **Marital Status (circle one)**  **Single / Mar / Div / Sep / Wid** | | | | | | |
| **Is this your legal name?** | | | **If not, what is your legal name?** | | | | | | | | **(Former name):** | | | | **Birthdate:** | | | | **Age:** | | **Sex:** |
| **Street address:** | | | | | | | | **Social Security no:** | | | | | | | **Home phone no:**  **( )** | | | | | | |
| **P.O Box:** | | | | **City:** | | | | | **State:** | | | | | | | **ZIP code:** | | | | | |
| **Occupation:** | | | | **Employer:** | | | | | | | | **Employer phone no:** | | | | | | | | | |
| **Chose clinic because/referred to clinic by (please check one box)  Dr.  Insurance Plan  Hospital** | | | | | | | | | | | | | | | | | | | | | |
| **Other family members seen here: Preferred Language: (circle) English / Spanish / Other\_\_\_\_\_\_\_\_\_\_\_\_**  **Email address: Ethnicity  Not Hispanic or Latino  Hispanic or Latino (optional)**  **Preferred method of contact Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (optional)**  **Home Phone: Cell Phone: Email:** | | | | | | | | | | | | | | | | | | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | | | | | | | | | | | | | |
| **(Please give your ID and Insurance Card to the Receptionist)** | | | | | | | | | | | | | | | | | | | | | |
| **Person responsible for the bill:** | | | **Birth date:** | | | | **Address (if different)** | | | | | | | | | | **Home phone no:** | | | | |
| **Is this person a patient here?  Yes  No** | | | | | | | | | | | | | | | | | | | | | |
| **Occupation:** | | **Employer** | | | | | **Employer address:** | | | | | | | | | | **Employer phone no:** | | | | |
| **Is this patient covered by insurance?** | | | | | | | | | | | | | | | | | | | | | |
| **Please indicate primary insurance  BCBS PPO  HUMANA  UNITED HEALTH CARE  CIGNA  AETNA**  **BCBS HMO  HUMANA HMO  MEDICARE  MEDICAID  OTHER** | | | | | | | | | | | | | | | | | | | | | |
| **Subscriber’s name:** | **Subscriber’s S.S. no:** | | | | | **Birth date** | | | | | | **Group No:** | | | | | | **Policy No:** | | **Copayment** | |
| **Patient’s relationship to subscriber:  Self  Spouse  Child  Other** | | | | | | | | | | | | | | | | | | | | | |
| **Name of secondary insurance (if applicable)** | | | | | **Subscriber’s Name**  **Date of birth / /** | | | | | | | | | **Group No:** | | | | | **Policy No:** | | |
| **Patient’s relationship to subscriber:  Self  Spouse  Child  Other** | | | | | | | | | | | | | | | | | | | | | |
| **IN CASE OF EMERGENCY** | | | | | | | | | | | | | | | | | | | | | |
| **Name of local friend or relative (not living at same address): Relationship to patient Home Phone No: Work phone No:** | | | | | | | | | | | | | | | | | | | | | |
| **The above information is true to the best of my knowledge; I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Orthopaedic Knee Shoulder & Sports Surgery or insurance company to release any information required to process my claims. I designate Orthopaedic Knee Shoulder & Sports Surgery to act as the authorized representative for any subsequent appeals related to benefit denials. If patient is under 18 years of age, parent or guardian please sign below.**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Patient/ Guardian signature Date** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |

**(PLEASE PRINT)**

**ORTHOPAEDIC KNEE SHOULDER AND SPORTS SURGERY**

**MICHAEL M. HECKMAN, M.D.,P.A**

**Welcome to our Clinic! We appreciated the opportunity to work with you. The following information is provided for your benefits so that we may serve you better. Please read and sign at the bottom. A copy will be given for your records.**

1. **Payments. All applicable fees, deductibles, co- insurance, or co-pays must be paid at the time of your appointment**
2. **Cancellations/ No Show: If you need to cancel your appointment please call us 24 hours prior to your appointment time. We reserve the right to bill you a $ 40.00 fee to cover our administrative costs. An appointment will not be made until the NO SHOW fee is paid.**
3. **Appointment time: we ask that our patient arrive on time for their appointments. This will facilitate our ability to see you as scheduled. In an effort to serve all of our patients arriving past their appointment may be rescheduled.**
4. **HMO & PPO Referrals: If your policy requires written authorization from your Primary Care Physician, we will request authorization. In advance, for the established patients. This is done as a courtesy for our patients; however we cannot guarantee authorization will be granted. Please keep in touch with your physician to ensure your visit is pre-authorized, to avoid having the financial responsibility for medical services provided to you.**
5. **Change of information: Please provide us with any change regarding your address, phone number or insurance information as soon as possible. Change of insurance will require the completion of a new patient demographic form and may not be changed over the phone.**
6. **Medication refill requests: Please contact your pharmacy first, they will contact our office for authorization of the refill.**
7. **After hours care: In an emergency, please dial our main number at 210.558.4600 and leave a message with the answering service. In a life threatening emergency call 911.**
8. **Medical records request: Request for copies of your medical records must be made in writing on a form provided by our office. Our office will respond within 15 days to properly complete written request. FEES: As per the rules adopted by Texas State Board of medical examiners, our office will charge $ 25.00 for the first 20 pages and .50 for each page thereafter and the actual cost of mailing, shipping or deliver where applicable.**
9. **Completion of forms: As per the rules adopted by the Texas State Board of medical examiners our office will respond to the requests for the completion of medical forms following the receipt of the appropriate fees. Forms will be completed within five business days.**
10. **Collections Agency Fee: In the event that your account is turned over for collection to a collection agency you will be responsible for the collection agency fees.**
11. **Ownership Disclosure: Michael M. Heckman, M.D. has ownership in Foundation Surgical Hospital, and Specialty Imaging. You may be referred to one or more of these in the course of your treatment.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature Patient Name Date**

**HIPAA OMNIBUS RULE**

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT / LIMITED**

**AUTHORIZATION & RELEASE FORM**

**You may refuse to sign this acknowledgement & authorization, in refusing we may not be allowed to process your insurance claims.**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ASLO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITES IN THE FUTURE.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please print name of the patient Please sign for patient / Guardian of patient**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Legal Representative / Guardian Relationship of Legal Representative / Guardian**

**How do you want to be addressed when summoned from the reception area:**

** First name only  Proper surname  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I authorize contact from this office to CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:**

** Cell Phone Confirmation  Text Message to my cell phone**

** Home Phone Confirmation  Email confirmation**

** Work Phone Confirmation  Any of the above**

**I authorize Information about my health be conveyed Via:**

** Cell Phone Confirmation  Text message to my cell phone**

** Home Phone Confirmation  Email Confirmation**

** Work Phone  Any of the above**

**I approve being contacted about SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFO on behalf of this Healthcare facility Via:**

** Phone Message  Any of the above**

** Text Message  None of the above (opt out)**

** Email**

**In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We under current HIPAA OMBINUS RULE, provide you this information with your knowledge and consent.**

**Office use only**

**As Privacy Officer, I attempted to obtain the patients {or representatives} signature on this acknowledgement but did not because**

**It was emergency treatment \_\_\_\_\_\_\_\_\_**

**I could not communicate with the patient \_\_\_\_\_\_\_\_\_**

**The patient refused to sign \_\_\_\_\_\_\_\_\_**

**The patient was unable to sign because \_\_\_\_\_\_\_\_\_**

**Other {please describer} \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Privacy Officer**

**ASSIGNMENT OF BENEFITS**

**Private insurance authorization for assignment of benefits and information release:**

**I, the undersigned authorize payment of medical benefits to Michael Heckman. M.D., P.A for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize Michael Heckman, M.D., P.A to release to my insurance company, referring physician and other consultants on my case information concerning health care advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administrating claims of benefits.**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CERTIFICATION**

**Michael M. Heckman M. D., P.A. is pleased to offer you treatment. However, you are advised that according to most commercial insurance policies and generally accepted practice, treatment for work related chronic injuries must first be filed under Texas Workman’s Compensation.**

**I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby certify that I am / am not seeking treatment for an illness injury that resulted from an incident/accident at my place of work or from a motor vehicle accident.**

**MVA / Date of incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT**

**By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of Michael M. Heckman, M.D., P.A.. I authorize release for my records to:**

* **Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Family Member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Coach/Trainer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Adjuster (WC ONLY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Nurse Case Manager (WC ONLY) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRESCRIPTION HISTORY AUTHORIZATION**

**I authorize Michael M. Heckman M.D. and his staff to download my prescription history for record keeping and treatment history.**

**Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Orthopaedic Knee, Shoulder & Sports Surgery**

**Michael M. Heckman, M.D., P.A**

|  |
| --- |
| **Record Release Form** |

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S.S.#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize the Orthopaedic Knee, Shoulder & Sports Surgery/ Dr. Michael Heckman to:**

**\_\_\_\_\_\_ request and receive records from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_ Release my records to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Which includes, but not limited to:**

**Office Reports Therapy Reports Lab Results**

**Operative Reports Routine X-ray Film & Report (s) MRI Films & Report (s)**

**CT Scan Films & Report (s) Arthogram Films & Report (s) NC/EMG Report**

**This authorization covers the patients care from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Purpose of disclosure: \_\_\_\_\_\_\_\_Medical Care \_\_\_\_\_\_\_\_\_Attorney \_\_\_\_\_\_\_\_\_\_\_Ins. Co.**

**\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This authorization shall be valid for 180 days from the date of signature. The patient can revoke this authorization in writing at any time prior to the expiration date.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature or Guardian Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**9502 Huebner Rd., Suite #: 301 San Antonio, Texas, 78240 Ph: 210.558.4600 Fax: 210.558.4605**

**www.sanantoniosportsmedicine.com**

**Orthopaedic Knee Shoulder & Sports Surgery**

**Michael M. Heckman MD**

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_ Chart No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_**

**Primary/ Family Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did he/she refer you? YES/NO**

**Referred by circle one: Website, Google, Friend, Former Patient, Urgent Care, Insurance plan, Online Reviews, Physician (name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason for your visit and is this the Right or Left? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Hand Dominance is: Right / Left / Ambidextrous**

**How did it happen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When did it happen? \_\_\_\_\_\_\_\_\_\_\_\_\_ Is this an ongoing problem? Yes/No If yes, how long? \_\_\_\_\_\_\_\_\_\_**

**Have you received any treatment for this problem? If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had any studies performed? Yes/No, if yes, which studies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe the pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (sharp, dull aching, burning, constant, and intermittent)**

**Does the pain radiate or move to another area, if yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What makes the pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has the pain changed since the onset? (Better, worse, different) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are there prior injuries to this area? Yes/No . If yes, how and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Did you receive any treatment for prior injury? Yes/No. If yes , prior treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**On a scale of 0 for No Pain to 10 for unbearable Pain, what is your pain level NOW? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**With this current injury, what is the Worst pain level you have had? \_\_\_\_\_\_\_ Least pain level \_\_\_\_\_\_\_\_\_\_\_**

**Do you have any associated symptoms? (Swelling, numbness, tingling, bruising) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is this a Work related injury? Yes /No. If yes, Date of Injury entered by employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is this a Sports injury? Yes /No. If yes, what school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is an Attorney involved? Yes / No. If yes, Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Vital Signs: Ht: \_\_\_\_\_\_\_\_ Wt: \_\_\_\_\_\_\_\_ BP: \_\_\_\_\_\_\_\_ Pulse \_\_\_\_\_\_\_\_**

**ORTHOPAEDIC KNEE SHOULDER AND SPORTS SURGERY**

**ADDITIONAL INFORMATION: CIRCLE CORRECT ANSWER**

1. **Have you ever had a Pneumonia Vaccination? Yes No**

**If yes, When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Have you ever had an influenza Vaccination? Yes No**

**If yes, when was the last vaccination? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Have you been told to have Osteoporosis (thinning of the bones)? Yes No**
2. **Have you had a bone density study? Yes No**

**If so when was your last study? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **In the event that you are unable to make a decision concerning your medical care, who would you want to make decisions for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Was the injury we are seeing you for today due to a fall? Yes No**
3. **Have you fallen in the past 12 months? Yes No**

**If yes, when did it occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **If you have arthritis, have you tried over the counter Medications?**

**Yes No Which ones? Tylenol Ibuprofen Aspirin**

**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Past Medical History**

**Please check all that apply**

* Anxiety  Diverticulitis  Kidney Disease
* Arthritis  Fibromyalgia  Kidney Stones
* Asthma  Gout  Leg/ Foot Ulcers
* Bleeding Disorder  Has Pacemaker  Liver Disease
* Blood Clots { or DVT}  Heart Attack  Osteoporosis
* Cancer  Heart Murmur  Polio
* Coronary Artery Disease  Hiatal Hernia or Reflux Disease  Pulmonary Embolism
* Claustrophobic  HIV or AIDS  Reflux or Ulcers
* Diabetes – Insulin  High Cholesterol  Stroke
* Diabetes – non-insulin  High Blood Pressure  Tuberculosis
* Dialysis  Under active Thyroid  Other

**Past Surgical History**

Surgery Reason Year Hospital

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Health History**

RELATION ALIVE? AGE SIGNIFICANT HEALTH PROBLEMS

Grandmother (maternal) Y/N \_\_\_\_  Alcoholism  Arthritis  Depression  Cancer  Diabetes  Genetic Disease

 Heart disease  Hypertension  Osteoporosis  Stroke

Grandfather (maternal) Y/N \_\_\_\_  Alcoholism  Arthritis  Depression  Cancer  Diabetes  Genetic Disease

 Heart disease  Hypertension  Osteoporosis  Stroke

Grandmother (paternal) Y/N \_\_\_\_  Alcoholism  Arthritis  Depression  Cancer  Diabetes  Genetic Disease

\_  Heart Disease  Hypertension  Osteoporosis  Stroke

Grandfather (paternal) Y/N \_\_\_\_  Alcoholism  Arthritis Depression  Cancer  Diabetes  Genetic Disease

 Heart disease  Hypertension  Osteoporosis  Stroke

Father Y/N \_\_\_\_  Alcoholism  Arthritis  Depression  Cancer  Diabetes  Genetic Disease

 Heart disease  Hypertension  Osteoporosis  Stroke

Mother Y/N \_\_\_\_  Alcoholism  Arthritis  Depression  Cancer  Diabetes  Genetic Disease

 Heart disease  Hypertension  Osteoporosis  Stroke

Brother/Sister Y/N \_\_\_\_  Alcoholism  Arthritis  Depression  Cancer  Diabetes  Genetic Disease

Heart disease  Hypertension  Osteoporosis  Stroke

Brother/Sister Y/N \_\_\_\_  Alcoholism  Arthritis  Depression  Cancer  Diabetes  Genetic Disease

 Heart disease  Hypertension  Osteoporosis  Stroke

Other: Y/N \_\_\_\_  Alcoholism  Arthritis  Depression  Cancer  Diabetes  Genetic Disease

 Heart disease  Hypertension  Osteoporosis  Stroke

**SOCIAL HISTORY**

**Occupation** **Caffine**  None **Tobacco:** Do you use tobacco  yes  no

**Education**  Less than 8th grade  High School  Occasional  Moderate  Heavy If not currently, did you ever use tobacco?

# of cups / cans per day?\_\_\_\_\_\_\_\_\_  Yes  No

 2 year college  4 year college  Post Graduate **Alcohol:** Do you drink alcohol ?  Cigarettes \_\_pks/day

If so, how often  Cigars  Chew

**Marital Status**  Married  Single Occasionally < 3 times a week  Chew

 Divorced  Separated  Widowed > 3 times a week  # years of

 Domestic partner How many drinks per week? Or year quit

Exercise Level None ( No exercise )

Occasional exercise **Drugs:** Do you currently use recreational or

Moderate exercise street drugs?  Yes  No

High level exercise If Yes list:

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**Review of Systems**

**Please check all that apply: Ears/Nose/Mouth/Throat Genitourinary Neurological**

** Bleeding Gums  Blood in urine  Dizziness**

**Allergic /Immunologic  Difficulty hearing  Difficulty urinating  Fainting**

 **Dizziness  Incomplete Emptying  Headaches**

**Frequent Sneezing  Dry Mouth  Increased urinary Frequency  Memory Loss**

** Hives  Ear Pain  Urinary Loss of Control  Migraines**

** Itching  Frequency Infections  Numbness**

** Runny nose  Frequent nosebleeds  Weakness**

** Sinus Pressure  Hoarseness Hemraologic/Lymphatic  Restless legs**

** Mouth Breathing  Easy Bruising / Bleeding  Seizures**

**Cardiovascular  Mouth Ulcers  Swollen Glands**

** Arm Pain on Exertion  Nose/Sinus Problems**

** Chest Pain on Exertion Integumentary (Skin) Psychiatric**

** Chest Heavines/Pressure on Exertion  Changes in Moles  Alcohol Oversure**

** Irregular Heart Beats  Dry Skin  Anxiety/ Stress**

**(Palpations) Endocrine  Eczema  Depression**

** Known Heart Murmer  Fatigue  Growth/ Lesions  Do Not feel safe in**

** Light-headed on Standing  Increased  Itching Relationship**

** Shortness of Breath When (Thirst/Hunger/Urination)  Jaundice (Yellow Skin/Eyes)  Mania**

**Walking** ** Rash  Sleep Problems**

** Swelling (Edema) Gastrointestinal**

** Abdominal Pain Musculoskeletal Respiratory**

**Constitutional  Black or Tarry Stool  Back Pain  Cough**

** Exercise Intolerence  Blood in Stool  Joint Pain  Coughing Up Blood**

** Fatigue  Change in Appetite  Muscle Aches  Shortness of Breath**

** Fever  Frequent Indigestion  Muscle Weakness  Sleep Apnea**

** Weight Gain (\_\_\_) lbs  Hemorrhoids  Snoring**

** Weight Loss (\_\_\_) lbs  Trouble Swallowing Eyes  Wheezing**

** Vomiting  Dry Eyes**

** Vomiting blood  Irritator**

** Vision Change**

**Date of Last Exam:\_\_\_\_\_\_**

**Allergies**

**List everything that are allergic to (medications, food, bee stings, ect.) and how each affects you:**

**Allergy: Reaction:**

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**Your Pharmacy Name & Number**

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**Medications**

**Please list all the medications you are taking, include prescribed drugs and over–the-counter drugs such as vitamins and inhalers:**

**Drug Name: Strength Frequency Taken**

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**Patient, Guardian or caregiver Signature DATE:**

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