Patient Demographics:

Patient Name: _____ _____
First MI Last Preferred Name

SS#: _____ Date of Birth: _____ Sex: Male Female

Address: _____ _____ _____ _____
Street address City State Zip Code

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____

Marital Status: Married Single Divorced Widowed

Race: African American American-Indian Asian Caucasian Hispanic Other

Guardian Information: (If Patient is a Minor)

Name: _____ Relationship to Patient: _____

SS#: _____ Birth Date: _____ Sex: Male Female

Address: _____ _____ _____ _____
Street address City State Zip Code

Home #: _____ Cell #: _____ Work #: _____

Payment Information:
Form of Payment: Health Insurance Auto Insurance Workers Comp Self Pay

Primary Insurance
Primary Company: _____ Insured's Name: _____
Policy #: _____ Group: _____ Insured's Date of Birth: _____

Secondary Insurance
Secondary Company: _____ Insured's Name: _____
Policy #: _____ Group: _____ Insured's Date of Birth: _____

Self-Pay Agreement
I agree to pay for medical services rendered at Andrews Orthopaedic and Sports Medicine Center. I understand that there are payment plans available at my request.
X _____ Date: _____

Release of Information: I authorize Andrews Orthopaedic and Sports Medicine Center to release medical information requested by my health insurance, Medicare, or third-party payers in order to assist in the payment of claims.
X _____ Date: _____

ANDREWS INSTITUTE
ORTHOPAEDICS & SPORTS MEDICINE

An Affiliate of Baptist Heath Care

Date: _____

Name: _____ Preferred Name: _____

Age: _____ DOB: _____

Referring Physician: _____

Primary Care Physician: _____

Pharmacy Name: _____ Street: _____

City: _____

Height: _____ Weight: _____

Reason for today's visit: _____

Right or left side: _____

Is this visit due to injury or accident? Yes _____ No _____ Date of Injury: _____

How did it happen?

_____

Where is pain located? _____

How would you describe the pain? (sharp, aching, etc.) _____

How would you currently rate the pain on a scale of 1 to 10? _____

What activities make your pain worse? _____

What activities make your pain better? _____

Have you had any imaging taken? (X-rays, MRI, etc.) _____

_____

Previous treatments: _____

Please indicate if you are currently experiencing any of the following conditions:

Review of Systems

Constitutional	Yes	No
Fever	☐	☐
Chills	☐	☐
Weight loss	☐	☐
Fatigue	☐	☐
Profuse Sweating	☐	☐
Weakness	☐	☐

Skin	Yes	No
Rash	☐	☐
Itching	☐	☐

Head, Ears, Nose & Throat	Yes	No
Headaches	☐	☐
Hearing Loss	☐	☐
Ring in ears	☐	☐
Ear Pain	☐	☐
Ear Discharge	☐	☐
Nose Bleeds	☐	☐
Congestion	☐	☐
Wheezing	☐	☐
Sore Throat	☐	☐

Eyes	Yes	No
Blurred Vision	☐	☐
Double Vision	☐	☐
Sensitive to Light	☐	☐
Eye Pain	☐	☐
Eye Discharge	☐	☐
Eye Redness	☐	☐

Cardiovascular	Yes	No
Chest Pain	☐	☐
Pounding Heart	☐	☐
Short of Breath relieved by sitting up	☐	☐
Leg Swelling	☐	☐
Shortness of breath during Sleep/Rest	☐	☐

Respiratory	Yes	No
Cough	☐	☐
Coughing up Blood	☐	☐
Phlegm Production	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

Gastrointestinal	Yes	No
Heartburn	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Stomach Pain	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in Stool	☐	☐
Dark Tarry Stools	☐	☐

Genitourinary	Yes	No
Painful Urination	☐	☐
Urgency	☐	☐
Frequency	☐	☐
Blood in Urine	☐	☐
Side Pain	☐	☐

Musculoskeletal	Yes	No
Muscle Pain	☐	☐
Neck Pain	☐	☐
Back Pain	☐	☐
Joint Pain	☐	☐
Falls	☐	☐

Endo/Heme/Allergies	Yes	No
Easy Bruise/bleed	☐	☐
Environmental Allergies	☐	☐
Polydipsia (Excessive thirst)	☐	☐

Neurological	Yes	No
Dizziness	☐	☐
Tingling	☐	☐
Tremors	☐	☐
Change in Sense of Touch	☐	☐
Speech Change	☐	☐
Hand, Arm, or Leg Weakness	☐	☐
Seizures	☐	☐
Loss of Consciousness	☐	☐

Psychiatric	Yes	No
Depression	☐	☐
Suicidal Ideas	☐	☐
Substance Abuse	☐	☐
Hallucinations	☐	☐
Nervous/Anxious	☐	☐
Sleeping Disorder	☐	☐
Memory Loss	☐	☐

Any Other Symptoms: _____

Medical History	Yes	No		Yes	No		Yes	No
Allergies	☐	☐	Lung Disease	☐	☐	Meningitis	☐	☐
Anemia	☐	☐	Depression	☐	☐	Nerve/Muscle disease	☐	☐
Anxiety	☐	☐	Diabetes Mellitus	☐	☐	Osteoporosis	☐	☐
Arthritis	☐	☐	Acid Reflux	☐	☐	Seizures	☐	☐
Asthma	☐	☐	Glaucoma	☐	☐	Sickle Cell	☐	☐
Blood Transfusion	☐	☐	Gout	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Heart Attack	☐	☐	Substance Abuse	☐	☐
Cataracts	☐	☐	HIV/AIDS	☐	☐	Thyroid Disease	☐	☐
Congestive Heart Failure	☐	☐	Kidney Disease	☐	☐	Tuberculosis	☐	☐
Clotting disorder (i.e., blood clot)	☐	☐	High Cholesterol	☐	☐	Ulcers	☐	☐
High Blood Pressure	☐	☐				Anesthetic Complications	☐	☐

Any Other Medical History: _____

Surgical History	Yes	No		Yes	No		Yes	No
Appendix	☐	☐	Cosmetic Surgery	☐	☐	Joint Replacement	☐	☐
Brain Surgery	☐	☐	C-Section	☐	☐	Small Intestine Surgery	☐	☐
Breast Surgery	☐	☐	Eye Surgery	☐	☐	Spine Surgery	☐	☐
Open Heart or Bypass	☐	☐	Fracture Surgery	☐	☐	Tubes Tied	☐	☐
Gall Bladder	☐	☐	Hernia repair	☐	☐	Valve Replacement	☐	☐
Colon Surgery	☐	☐	Hysterectomy	☐	☐			

Any Other Surgical History: _____

CURRENT MEDICATIONS: PRESCRIPTION/NON-PRESCRIPTIONS

NAME OF MEDICATION	DOSAGE

ALLERGIES (MEDICATIONS, FOOD, SEASONAL, ETC)

NAME OF MEDICATION	DESCRIBE ADVERSE REACTION

Key: Paternal = Fathers Side. Maternal = Mothers Side

Family Medical History

Instructions: Please check the box of positive family medical history

Relationship	Arthritis	Asthma	Birth Defects	Cancer	Depression	Diabetes	Early Death	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Learning disability	Mental illness	Other	Stroke	Substance Abuse	Vision Loss
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal GM	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal GF	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal GM	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal GF	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Social History

Patient lives with: _____ Is this patient adopted? ◯ Yes ◯ No

Brothers: _____ Sisters: _____ Grade in School: _____

Tobacco Use

Current Use ◯ Yes ◯ No Packs/Day: _____ # of Years: _____

Former Use ◯ Yes ◯ No Packs/Day: _____ Quit Date: _____ # of Years: _____

Smokeless Tobacco ◯ Yes ◯ No Quit Date: _____

Comments: _____

Alcohol Use

◯ Yes ◯ No

Drinks/Week

_____ Glasses of Wine

_____ Cans of Beer

_____ Shot of Liquor

_____ Drinks containing 0.5 oz of alcohol

Comments: _____

Drug Use

◯ Yes ◯ No

Per week: _____ Types: ◯ Marijuana ◯ Methamphetamines

◯ Cocaine ◯ IV

Disclosure to Release Information to Families/Emergency Contacts and Physicians

I authorize Baptist Physicians Group to disclose my health care information and to discuss my health care needs with those that I designate. I further authorize the release of my billing information to the following individuals and give them the ability to pick up prescriptions and/or from, etc. on my behalf. A photo ID is required for any pick up. These individuals will be considered my emergency contacts. Without authorization, no information may be shared.

Important Note: If you may want or need any healthcare information or scheduling information released to any individuals they need to be specifically listed below. This includes individuals such as: a parent or child of a patient over 18 years of age, your primary care physician, your insurance policy holder, and/or sport coaches etc.

I authorize Baptist Physicians Group and its staff to disclose my personal health information to the following people:

Name: _____ Relationship: _____ Phone: _____

Name: _____ _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Consent to Treatment

I hereby grant authorization and consent for medical treatment and/or procedures for myself or for the patient for whom I am the parent or legally authorized guardian, and I understand that no guarantees or assurance has been made as to the results for which may be obtained.

_____
Patient or Guardian Initials

Photo Documentation

I hereby grant authorization for the office staff to make a copy of my photo identification to be included in my confidential record as well as take a digital picture as additional protection against the theft of my medical identity. I further grant authorization for the office staff to take photo identification of any injury or procedure that they feel is medically necessary.

_____
Patient or Guardian Initials

Notice of Privacy Practices

I have reviewed a copy of the Baptist Health Care "Notice of Privacy Practices" and understand that a copy is available upon request, I agree with these policies.

_____
Patient or Guardian Initials

Insurance Assignment and Financial Responsibility

I hereby authorize Baptist Physician Group to release any medical information required during the course of examination and treatment to my insurance company and/or third-party payers in order to assist in the payment of claims. I permit payment to Baptist Physician Group from my insurance for services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to co-insurance, co-payment, deductible, and non-covered services. I understand that I am responsible for all charges incurred regardless of the insurance status. I agree to pay my bill in full for services rendered by Baptist Physician Group.

_____
Patient or Guardian Initials

Print Name of Patient or Guardian: _____

Relationship to patient: _____

Patient or Guardian Signature: _____ Date: _____