PATIENT DEMOGRAPHICS:

Patient Name: _____ _____
First MI Last Preferred Name

DOB: _____ **Sex:** MALE FEMALE **SSN:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _(_____)_____ **Cell Phone:** _(_____)_____

Marital Status: Married Single Divorced Widowed **Ethnicity:** Hispanic/Latino Non-Hispanic/Latino

Race: African-American American-Indian Asian White Hispanic Other: _____

Email Address: _____

GUARDIAN INFORMATION (If patient is a minor):

Name: _____ **Relationship:** _____
First MI Last

DOB: _____ **Sex:** MALE FEMALE **SSN:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _(_____)_____ **Cell Phone:** _(_____)_____

PAYMENT INFORMATION:

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

Primary Insurance
Insurance Company: _____

Policy Number: _____ Group Number: _____

Insured's Name: _____ Insured's DOB: _____

Secondary Insurance
Insurance Company: _____

Policy Number: _____ Group Number: _____

Insured's Name: _____ Insured's DOB: _____

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

X_____ Date: _____

Additional Medical Forms: All medical paperwork including but not limited to, FMLA paperwork, disability forms, and short term-disability paperwork, will be processed in 7-10 business days. Please note this paperwork comes with a onetime service charge of $25.00. Paperwork will not be processed until payment has been received.

Complete the following ONLY if your records need to be forwarded:

Referring Physician: _____ Facility: _____

Contact Number: _____ Fax: _____

Primary Care Physician: _____ Facility: _____

Contact Number: _____ Fax: _____

Coach/Trainer/Team Doctor: _____ School: _____

Contact Number: _____ Fax: _____

TO ALL PATIENTS:

It is the patient's responsibility to obtain previous medical records (MRI reports, surgical reports, office notes, etc.) or diagnostic testing (MRIs, EMG studies, X-rays, etc. on a DISC). These records must be provided at the time of your visit unless otherwise notified.

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

We are legally required to give you this Notice and to get a signed statement that you received it. By signing this form, you are saying that you have received the Andrews Orthopaedic and Sports Medicine Center's Notice of Privacy Practices.

This Notice of Privacy Practices tells you how we can use and disclose your health information. It also describes certain rights you have about your health information kept by us. Please review the Notice of Privacy Practices carefully.

The undersigned hereby acknowledges receipt of Notice of Privacy Practices for Andrews Orthopaedic and Sports Medicine Center.

_____ _____

Patient's Printed Name Patient's Signature Date

_____ _____

Guardian Printed Name Relationship Signature

CHIEF COMPLAINT

Name:_____

DOB: _____ **Age:** _____

Occupation/Job: _____

Primary Care Physician: _____

Height: _____ **Weight:** _____

Pharmacy: _____

Injury (Please circle):
SHOULDER KNEE HIP OTHER:_____

Which side (Please circle):
LEFT RIGHT BOTH

What symptoms are you having:

PAIN	SWELLING
POPPING	STIFFNESS
GIVING AWAY	INSTABILITY
WEAKNESS	NUMBNESS
CATCHING	OTHER

How did you injure yourself?:

No injury – it just started hurting
Sports (Which sport):_____
Motor vehicle accident
Worker's compensation claim

What is the date of injury/onset: _____

How long have you had symptoms:

_____days _____months _____years

Briefly describe the injury or pain:

_____

_____

Diagnosis (If given): _____

Previous treatment (injections, PT, bracing, etc.):

_____

_____

Previous surgery:

_____

_____

How severe is the pain (0=NONE, 10=WORST):
AT REST: _____ AT WORST: _____

What makes your pain better:

_____

_____

What makes it worse:

_____

_____

Describe your current limitations:

_____

_____

Have you had: XRAYS MRI CT SCAN

Interested in surgery if offered? YES NO

Do you drink alcohol: YES NO
If yes, how often: _____

Do you smoke: YES NO
If yes, how often: _____

Do you use smokeless tobacco: YES NO

Have you ever used illicit drugs: YES NO

Do any medical conditions run in your family:

_____

_____

_____

Do you have any allergies to medications:

_____

_____

PLEASE FILL OUT THIS FORM WITH ANY NEW OR UPDATED MEDICAL CONDITIONS

Medications (Please list all that you are taking):

MEDICATION	DOSAGE	How do you take?(daily, twice daily, as needed, etc.)

Past medical history (Please circle):

Anemia	Gastric Ulcer	High Cholesterol	Pulmonary Embolism
Arthritis	Glaucoma	Immune Deficiency	Reflux
Arrhythmia	Gout	Liver Disease	Skin Ulcer
Asthma	Heart Attack	Kidney Disease	Steroid Use
Cancer	Heart Failure	MRSA	Stroke
Chest Pain	Heart Murmur	Neuropathy	Thyroid Disease
Deep Vein Thrombosis	Hepatitis	Paralysis	Tuberculosis
Diabetes	High Blood Pressure	Pneumonia	Vascular Disease
Gall Bladder Disease	HIV/AIDS	Psychiatric Illness	Wound Healing Issues

Other: _____

Review of Systems (Please circle which applies):

1. **GENERAL**
   Recent weight change Chills Fever Weakness/Fatigue None
   Other:_____
2. **EYES**
   Vision change Glasses/contacts Cataracts Glaucoma None
   Other:_____
3. **EARS, NOSE, THROAT**
   Loss of hearing Ear ache/infections Ringing in ear Hoarseness None
   Other:_____
4. **CARDIOVASCULAR**
   Chest pain Swelling in legs Shortness of breath Palpitations None
   Other: _____
5. **RESPIRATORY**
   Shortness of breath Wheezing/Asthma Frequent Cough None
   Other:_____

6. **GASTRONTESTINAL**

   Heartburn Acid reflux Nausea/vomiting Abdominal pain None

   Other: _____

7. **MUSCULOSKELETAL**

   Arthritis/Joint stiffness Muscle aches Swelling of joints None

   Other: _____

8. **SKIN**

   Rash Ulcers Abnormal scars Sores None

   Other: _____

9. **NEUROLOGICAL**

   Headaches Fainting/blackouts Dizziness None

   Other: _____

10. **PSYCHIATRIC**

    Depression Nervousness Anxiety Mood swings None

    Other: _____

11. **ENDOCRINE**

    Excessive thirst or hunger Hot/cold intolerance Hot flashes None

    Other: _____

12. **HEMATOLOGICAL**

    Easy bruising Easy bleeding Anemia None

    Other: _____