

**Orthopaedic & Sports Specialists  
Intake Form**

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

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Age: \_\_\_\_\_

Address: \_\_\_\_\_

Home Ph: \_\_\_\_\_

Cell: \_\_\_\_\_

SS#: \_\_\_\_\_

**1st Ins:** \_\_\_\_\_

**2nd Ins:** \_\_\_\_\_

Subscriber:  Self  Spouse  Parent

Subscriber:  Self  Spouse  Parent

ID# \_\_\_\_\_

ID# \_\_\_\_\_

Grp # \_\_\_\_\_

Grp # \_\_\_\_\_

**IS THIS RELATED TO AN INJURY AT WORK OR TO A MOTOR VEHICLE ACCIDENT?**  Yes  No

Employer: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Address: \_\_\_\_\_

Body Part: \_\_\_\_\_

Phone: \_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

PROVIDING QUALITY MEDICAL CARE FOR OUR PATIENTS IS OUR PRIMARY CONCERN. WE ARE MORE THAN WILLING TO PROVIDE THAT CARE WITHIN YOUR INSURANCE CONTRACT GUIDELINES IF YOU LET US KNOW AT EACH TIME OF SERVICE, EXACTLY WHAT THOSE GUIDELINES ARE.

UNFORTUNATELY, IF YOU DO NOT INFORM US OF ANY SPECIAL REQUIREMENTS IN YOUR CONTRACT AND WE SUBSEQUENTLY ORDER SERVICES SUCH AS X-RAYS, TESTING, MEDICAL SUPPLIES, THERAPY, OR HOSPITALIZATION THAT ARE NOT COVERED, WE OR THE SELECTED MEDICAL FACILITY WILL HAVE NO CHOICE BUT TO BILL YOU DIRECTLY FOR THOSE CHARGES. INJECTIONS MAY NOT BE COVERED BY YOUR INSURANCE PLAN. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR PLAN. PAYMENT FOR THOSE CHARGES WILL THEN **BECOME YOUR RESPONSIBILITY.**

**THERE WILL BE A \$35.00 CHARGE FOR ALL RETURNED CHECKS.**

I HEREBY AUTHORIZE ORTHOPAEDIC AND SPORTS SPECIALISTS, P.C. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

SIGNATURE \_\_\_\_\_

**AUTHORIZATION TO OBTAIN MEDICAL RECORDS**

PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT I \_\_\_\_\_

(PLEASE PRINT NAME)

HEREBY AUTHORIZE ORTHOPAEDIC & SPORTS SPECIALISTS TO OBTAIN MEDICAL RECORDS SPECIFICALLY RELATED TO MY TREATMENT. THIS PROTECTED HEALTH INFORMATION IS BEING USED BY THE FACILITY FOR THE PURPOSE OF PREPARATION FOR AN OUTPATIENT VISIT AT ORTHOPAEDIC AND SPORTS SPECIALISTS. THIS AUTHORIZATION SHALL BE IN FORCE AND EFFECT UNTIL WITHDRAWN BY MYSELF OR MY REPRESENTATIVE. I HAVE READ AND UNDERSTAND ORTHOPAEDIC AND SPORTS SPECIALISTS PRIVACY NOTICE ON HOW TO REVOKE OR WITHDRAW THIS AUTHORIZATION.

SIGNATURE \_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE**

IN THE EVENT THAT A REPRESENTATIVE OR FAMILY MEMBER WISHED TO DISCUSS YOUR PROTECTED HEALTH INFORMATION WITH THE DOCTOR, WE MUST HAVE YOUR PERMISSION TO DO SO. PLEASE FILL IN THE SPACE BELOW TO INDICATE THE NAME OF SUCH PERSON THAT YOU WILL ALLOW THE DOCTOR TO DISCUSS THE PROTECTED HEALTH INFORMATION WITH. I AUTHORIZE ORTHOPAEDIC AND SPORTS SPECIALISTS TO RELEASE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING REPRESENTATIVE/FAMILY MEMBER ON MY BEHALF: \_\_\_\_\_

I ACKNOWLEDGE THAT I HAVE RECEIVED ORTHOPAEDIC AND SPORTS SPECIALISTS PRIVACY NOTICE.

\_\_\_\_\_  
Signature Patient or Personal Representative

# Orthopaedic & Sports Specialists

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

Physical Assessment

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Primary Care MD: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

Do you have or have you ever had any of the following? Place a check in the box that applies:

Nervous System	Epilepsy/Seizures/Fainting Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No	GI/GU	Hiatal Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Stomach Ulcer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Loss of Consciousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	ADHD/ADD	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Unexplained Recent Weight			
	Cerebral Palsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Loss/Gain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Head Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Gastric Reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Headaches/Migraines	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Indigestion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Motion Sickness	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Psychosocial	Anxiety/Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Endocrine	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Counseling Service	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Mental Illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Insulin Dependent	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			Hypoglycemia		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Heart	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Musculo-skeletal	Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Painful Stiff Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Prosthesis: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Back Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Pacemaker/AID	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Metal Implants: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Physical Limitations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood	Bleeding Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Irregular Heartbeat	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Blood Transfusions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Palpitations/Skipped Beats	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Eye Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Heart Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Eye -- Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Lung	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Airway	Problem Opening Mouth Wide	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Hay Fever/Sinus	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Problem Turning Head in Any			
	Emphysema/COPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Direction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	Croup	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dental	Bridges, Crowns, Partials	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Previous Smoke: Quit _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Dentures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Current Smoke: _____ Cigs per day _____ Yrs.				Loose or Missing Teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		TMJ	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Recent Cold or Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Allergies	Latex	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	TB	<input type="checkbox"/> Yes	<input type="checkbox"/> No			Medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dyes/Tapes		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Chew Tobacco	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shellfish		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			Foods	<input type="checkbox"/> Yes		<input type="checkbox"/> No		
			List Allergies:					
Anesthesia	Nausea/Vomiting after Anesth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver	Hepatitis/Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Family History of Anesthesia Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
GYN	Last Menstrual period: _____				Alcohol Daily: _____ Socially: _____			
	Pregnancy Test: _____				Recreational Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Skin	Have you ever had MRSA?	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
	Treated by: _____							
	Open Lesions/Boils	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
	Description _____							
	Physician Notified	<input type="checkbox"/> Yes	<input type="checkbox"/> No					

Most Recent Hospital Admissions/Previous Surgeries/Serious Illness/Cancer: \_\_\_\_\_

Reviewed by Dr. Rosenberg: \_\_\_\_\_