Orthopaedic & Sports Specialists **Date:** ____________________

Intake Form

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 AUTHORIZASTION 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:** ____________________________

History

Name:____ Age:__________ **Primary Care MD:**____________________________

Occupation:____ Right Handed ________ Left Handed ________

Height:_________ Weight:__________ BMI:_________

Why are you seeing the Dr?_____________________________________

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

Category	Condition	Yes	No
Nervous System	Epilepsy/Seizures/Fainting Spells	Yes	No
	Stroke	Yes	No
	Loss of Consciousness	Yes	No
	ADHD/ADD	Yes	No
	Cerebral Palsy	Yes	No
	Head Injury	Yes	No
	Headaches/Migraines	Yes	No
Psychosocial	Anxiety/Depression	Yes	No
	Counseling Service	Yes	No
	Mental Illness	Yes	No
Heart	High Blood Pressure	Yes	No
	Chest Pain	Yes	No
	Angina	Yes	No
	Heart Attack	Yes	No
	Pacemaker/AID	Yes	No
	Mitral Valve Prolapse	Yes	No
	Heart Murmur	Yes	No
	Irregular Heartbeat	Yes	No
	Palpitations/Skipped Beats	Yes	No
	Heart Surgery	Yes	No
Lung	Asthma	Yes	No
	Hay Fever/Sinus	Yes	No
	Emphysema/COPD	Yes	No
	Shortness of Breath	Yes	No
	Croup	Yes	No
SMOKE:	Previous Smoke: Quit__________	Yes	No
	Current Smoke:________Cigs per day __________ Yrs.		
	Bronchitis	Yes	No
	Recent Cold or Cough	Yes	No
	TB	Yes	No
	Pneumonia	Yes	No
	Chew Tobacco	Yes	No
Anesthesia	Naseau/Vomiting after Anesth	Yes	No
	Family History of Anesthesia Problems	Yes	No
List Current Medications	______________________ ______________________ ______________________ ______________________ ______________________ ______________________ ______________________ ______________________		
Skin	Have you ever had MRSA?	Yes	No
	Treated by: ____________		
	Open Lesions/Boils	Yes	No
	Description ____________		
	Physcian Notified	Yes	No

Category	Condition	Yes	No
GI/GU	Hiatal Hernia	Yes	No
	Stomach Ulcer	Yes	No
	Kidney Disease	Yes	No
	Rapid Weight Loss/Gain	Yes	No
	Irritible Bowel Syndrome	Yes	No
	Gastric Reflux	Yes	No
	Indgestion	Yes	No
	Liver Disease	Yes	No
	Motion Sickness	Yes	No
Endocrine	Diabetes	Yes	No
	Thyroid Disease	Yes	No
	Insulin Dependent	Yes	No
	Hypoglycemia	Yes	No
Musculo-skeletal	Arthritis	Yes	No
	Painful Stiff Joints	Yes	No
	Prosthesis: ________	Yes	No
	Back Pain	Yes	No
	Metal Implants: ________	Yes	No
	Physical Limitations	Yes	No
Blood	Bleeding Disorder	Yes	No
	Blood Transfusions	Yes	No
	Eye Glaucoma	Yes	No
	Eye -- Other	Yes	No
Airway	Problem Opening Mouth Wide	Yes	No
	Problem Turning Head in Any Direction	Yes	No
	Sleep Apnea	Yes	No
Dental	Bridges, Crowns, Partials	Yes	No
	Dentures	Yes	No
	Loose or Missing Teeth	Yes	No
	TMJ	Yes	No
Allergies	Latex	Yes	No
	Medications	Yes	No
	Dyes/Tapes	Yes	No
	Shellfish	Yes	No
	Foods	Yes	No
	List Medication Allergies: ____________________ ____________________ ____________________ ____________________		
Liver	Hepatitis/Jaundice	Yes	No
	Liver Disease	Yes	No
	Alcohol Daily:______ Socially:_________		
	Recreational Drugs	Yes	No
GYN	Last Menstrual period:_________________		
	Pregnancy Test:		

Most Recent Hospital Admissions/Previous Surgeries/Serious Illness/Type of Cancer:

Reviewed by Dr. Rosenberg;____