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 THIS AUTHORIZASTION SHALL BE IN FORCE AND EFFECT UNTIL WITHDRAWN BY MYSELF OR MY REPRESENTATIVE.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:

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

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

Reviewed by Dr. Rosenberg;_____