

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

### PATIENT INFORMATION

Chart #: \_\_\_\_\_

\*\*\*All sections MUST be completed. If not applicable, please indicate as "N/A"\*\*\*

#### PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Nickname \_\_\_\_\_

Sex \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: S M W D

Permanent Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

Employer/School Name \_\_\_\_\_ Employed:  Full Time  Part Time Student:  Full time  Part time

Driver's License # & State \_\_\_\_\_ Primary Care / Family Physician's Name \_\_\_\_\_

Have you ever been treated by one of our physicians?  No  Yes, by Dr \_\_\_\_\_ Approximate Date \_\_\_\_\_

Was your injury sustained on the job?  Yes  No If yes, has a claim been filed with your employer?  Yes  No

#### EMERGENCY CONTACT

1st Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Hm  Wk  Cell Relationship \_\_\_\_\_

2nd Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Hm  Wk  Cell Relationship \_\_\_\_\_

**REFERRED BY**  Doctor  Hospital/Clinic  Patient  Friend/Co-Worker  Family Member  HMO/PPO Directory

Employer  Referral Service  Yellow Pages  Print Advertising  TV  Internet  Radio  School  Other \_\_\_\_\_

If referred by a physician: Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Phone # \_\_\_\_\_

If referred by another source, list specific name (i.e hospital, school, or friend's name) \_\_\_\_\_

#### PRIMARY INSURANCE (complete blanks below with *insured's* information)

#### SECONDARY INSURANCE (complete with *insured's* information)

Insured's Name \_\_\_\_\_

Insured's Name \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Patient's Relationship to Insured \_\_\_\_\_

Patient's Relationship to Insured \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co Name \_\_\_\_\_

Insurance Co Name \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Claims Filing Address \_\_\_\_\_

Claims Filing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

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

**GUARANTOR** (if other than patient) Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Sex \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License # & State \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Permanent Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby consent to releasing information for the purposes of treatment, payment, or health care operations.  
**ASSIGNMENT OF BENEFITS:** I hereby authorize my insurance benefits to be paid directly to Austin Sports Medicine. **CONSENT FOR TREATMENT:** I hereby consent to necessary examination procedures and/or treatment by my physician, his/her assistants, designees as is necessary in his/her judgment.

Date \_\_\_\_\_ Signature (patient, parent, or guardian) \_\_\_\_\_ Relationship \_\_\_\_\_

### Acknowledgement of Review of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

Patient Name: \_\_\_\_\_ Account Number: \_\_\_\_\_

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

Relationship to Patient (if other than patient): \_\_\_\_\_





# MEDICAL HISTORY

Please complete all sections and indicate if non-applicable.

Name \_\_\_\_\_ Date \_\_\_\_\_ Age \_\_\_\_\_ Sex (Circle one) M / F

Primary Physician (provide first & last name) \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

## ILLNESSES / REVIEW OF SYSTEMS (Provide details to all yes answers)

<i>Yes</i>	<i>No</i>	<i>Details</i>	<i>Medication</i>
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems/Pacemaker/Chest Pain _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Lung Disease/Shortness of Breath _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Disorders _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems/Stroke _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots/Phlebitis _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Bladder Infections _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer/Bleeding _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Depression/Mental Illness _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Change _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eyes, Vision Change _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ear, Nose, Throat, Mouth Problems _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Seizure _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other Illness/Hospitalization _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Previous Bone or Joint Problems _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other Sports Injury _____	_____

## DRUG ALLERGIES (Check yes or no)

*Yes No*  
  If yes, provide details \_\_\_\_\_  
\_\_\_\_\_

## LATEX ALLERGIES (Check yes or no)

If yes, provide details \_\_\_\_\_  
\_\_\_\_\_

## OTHER MEDICATIONS (current/recent)

*Yes No*  
  Diuretics \_\_\_\_\_  
  Blood Thinners \_\_\_\_\_  
  Steroids/Cortisone \_\_\_\_\_  
  Weight Control \_\_\_\_\_  
  Sleeping Pills \_\_\_\_\_  
  Antibiotics \_\_\_\_\_  
  Pain Pills \_\_\_\_\_  
  Aspirin \_\_\_\_\_  
  Anti-inflammatories (e.g. Advil) \_\_\_\_\_  
  Herbals/Vitamins/Supplements \_\_\_\_\_  
  Other \_\_\_\_\_  
\_\_\_\_\_

## PREVIOUS SURGERY

*Yes No*  
  PREVIOUS SURGERY (type and dates) \_\_\_\_\_  
\_\_\_\_\_

FAMILY HISTORY (illness, reactions to anesthesia) \_\_\_\_\_  
\_\_\_\_\_

RECENT TEST RESULTS (EKG, chest x-ray, blood or HIV tests, etc.) \_\_\_\_\_  
\_\_\_\_\_

RECENT ILLNESSES OR SYMPTOMS \_\_\_\_\_  
\_\_\_\_\_

SMOKE? (pack/day) \_\_\_\_\_

DRINK? (how often?) \_\_\_\_\_

## WOMEN ONLY

Pregnant? \_\_\_\_\_

Birth Control (type) \_\_\_\_\_

Date Last Period Started \_\_\_\_\_

Normal? \_\_\_\_\_

<i>For Office Use only</i>	<i>Date / Initials</i>
History Reviewed / Updated	_____
History Reviewed / Updated	_____
History Reviewed / Updated	_____
History Reviewed / Updated	_____

**NOTE:** This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person, except when you have authorized us to do so. I have read and answered completely and accurately.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_