Name: ________________________________

DOB: _______________________

☐ Mt. Lebanon ☐ Greensburg ☐ Warrendale

SPORTS MEDICINE & JOINT REPLACEMENT
S P E C I A L I S T S

Patient Name (PRINT First, Middle, Last):

____

Address: ________________________________

____

____

Contact Information

Home #: (__________) _________ - ____________

May we leave a message? ☐ **Yes** ☐ **No**

Work #: (__________) _________ - ____________

May we leave a message? ☐ **Yes** ☐ **No**

Cell #: (__________) _________ - ____________

May we leave a message? ☐ **Yes** ☐ **No**
May we send a text message? ☐ **Yes** ☐ **No**

Email: __________________________________

Emergency Contact

Name: __________________________________

Phone #: (__________) _________ - ____________

Relationship: ____________________________

Insurance Information

Primary Medical: __________________________

Policy #: ________________________________

Group #: ________________________________

Secondary Medical: ________________________

Policy #: ________________________________

Group #: ________________________________

DOB: ______________________

Gender: ______________________

SSN#: _______-______-_________

Marital Status: ________________

Race: ☐ White ☐ Black ☐ Other ☐ Declined to specify

Spouse Information

Name: ________________________

DOB: ________________________

Employer: _____________________

Language: ☐ English ☐ Spanish ☐ Other

Interpreter Required: ☐ Yes ☐ No

Primary Care Physician Information

Name: ________________________

Phone #: (______) ______ - _______

Referring Physician Information

Name: ________________________

Phone #: (______) ______ - _______

Is this a Workers Compensation claim?
☐ **Yes** ☐ **No**
Is this an Auto-Accident Claim?
☐ **Yes** ☐ **No**

If **YES**, please provide the following:

Date of Injury: ____________________

Attorneys Name: ____________________

Attorney's #: (______) _______-________

(Please complete WC Form)

Are you currently under contract with Pain Management? ☐ **Yes** ☐ **No**
If **YES**, please provide the following:

Name: ____________________________

Phone #: (_______) ________-__________

Address: __________________________

____

____

PLEASE FILL THIS PORTION OUT IF PATIENT IS A MINOR OR HAS A LEGAL GUARDIAN:

Primary Legal Guardian Name:

____

DOB: ______________________________

Address (ONLY if different from patients):

____

____

____

Name: ________________________________**DOB:** ________________________

Pharmacy Name: ______________________________ **Phone #:** (_________) ________ - ___________

Medications ☐ **NOT CURRENTLY TAKING ANY MEDICATIONS**

1 ______________________ 6______________________
2______________________ 7______________________
3______________________ 8______________________
4______________________ 9______________________
5______________________ 10______________________

Allergies ☐ **NO KNOWN DRUG ALLERGIES**

1 ______________________ 3______________________
2______________________ 4______________________

Social History/ Habits (*Check all that apply)*

- Cigarette Smoking *If* ***YES****, # of packs per day:* _______
- Former Smoker *If* ***YES****, quit date:* _____________
- Other Tobacco Use
- Alcohol Consumption
- Retired
- Illegal Drug Use
- Alcoholism
- On Disability

Do you work? **Yes** **No**

If ***YES****, where?* ________________________________

What is your title? ________________________________

List of hobbies/ sports that you enjoy:
____
____

Height ________ft _________in

Weight ______________lbs.

☐Left-Handed ☐Right-Handed

Do you live in a: ☐ Single level Home ☐ Multilevel Home

9.5

Family History (*Please fill in accordingly by marking with "X")*

Medical Problems/ History *(Check all that apply)*

- NONE KNOWN
- DVT/ Blood Clots
- Diabetes
- Osteoporosis
- Gastric Ulcer
- Gerd
- Hernia
- Fibromyalgia
- Gout
- Osteoarthritis
- RSD
- Lyme Disease
- Kidney Problems
- Heart Attack
- Stroke
- Heart Murmur
- Heart Failure
- Pneumonia
- Sleep Apnea
- Thyroid Disorder
- Tuberculosis
- Bronchitis
- Asthma
- COPD/ Emphysema
- High Blood Pressure
- High Cholesterol
- HIV/AIDS
- History of Mental Health Issues
- Hepatitis (*circle type below)*
  TYPE: **A** **B** **C**
- Parkinson's Disease
- Epilepsy/ Seizures
- Dementia
- Rheumatoid Arthritis
- Liver Disease
- Poor Circulation
- Cancer
- Substance Abuse
- Easy Bleeding
- Anemia
- Colitis

- NO SURGICAL HISTORY
- Hemorrhoidectomy
- Gallbladder Surgery
- Hysterectomy/ Tubal Ligation
- Tonsillectomy
- Adenoidectomy
- Metal Implants

Surgical History (*Check all that apply)*

- Pacemaker Implantation
  - *If **YES**, date?* ______________
- *Hernia Repair*
- *Heart Bypass*
- *Appendectomy*
- *Thyroid Surgery*
- *Cataract Surgery*
- Prostate Surgery
- Gastric Bypass
- Back Surgery
- Rotator Cuff Repair
- Knee Arthroscopy
- Total Joint Replacement Surgery

*If **YES**, which body part:* ____________________

Name: ___________________________________ **DOB:** _________________________

Injury Information/ Reason for Today's Visit

Affected Body Part(s): __________________________________

Describe How Injury Occurred: __________________________

Musculoskeletal Review of Symptoms

Date of Onset: _________________

Has been going on for: ____days ____wks ____mos. ____yrs

How did this problem start? (circle what applies) No Injury Injury

Onset was Gradual Onset was Sudden Auto Accident

Current Medical Status: *(Check ONLY what applies)*

Constitutional:

- Weight Change
- Interrupted Sleep
- Abnormal Fatigue
- Fever

Neurological:

- Dizziness
- Fainting
- Tingling
- Numbness

Skin Symptoms:

- Tattoo
- Skin Rash
- Surgical Scar
- Yellow Eyes or Skin

Cardiovascular

- High Blood Pressure
- High Cholesterol
- Heart Problems

Genitourinary:

- Blood in Urine
- Painful Urination
- Increased Urinary Frequency

Pulmonary:

- Sleep Apnea
- Asthma
- COPD

Psychological Symptoms:

- Anxiety
- Depression

Endocrine Symptoms:

- Diabetes
- Thyroid Disease

Hematological/Blood:

- Clotting Disorder
- Anemia

HEENT:

- Hearing Loss
- Dentures Currently
- Corrective Lenses

Gastrointestinal:

- Heartburn
- Gerd
- Nausea/ Vomiting
- Diarrhea

Other Not Listed:

____

____

____

Body Parts Involved *Check ONLY what applies – circle follow up question(s)*	**Pain Severity on a scale 1-10; 10 being the worse:** _______at best _______at worst

Body Parts Involved

Check ONLY what applies – circle follow up question(s)

- Shoulder Left Right
- Pelvis Left Right
- Arm Left Right
- Hip Left Right
- Elbow Left Right
- Knee Left Right
- Wrist Left Right
- Leg Left Right
- Finger Left Right 2 3 4 5
- Thumb Left Right
- Hand Left Right
- Ankle/foot Left Right
- Toe Left Right 2 3 4 5
- Lumbar *Does pain radiate?* __________
  - O *If **YES**, where does it radiate to?*

____

- Neck *Does pain radiate?* __________
  - O *If **YES**, where does it radiate to?*

____

Pain Severity on a scale 1-10; 10 being the worse:

_______at best _______at worst

Circle what applies

How would you best describe your pain?

Sharp Stabbing Throbbing Aching Dull Other

Does the pain wake you from sleep? Yes No

Which of the following, if any, makes symptoms better?

Bracing Elevation Heat Ice Injections Rest Medications

Which of the following, if any, makes symptoms worse?

Bending Climbing Stairs Exercise Kneeling
Running Lifting the body part Sitting Squatting
Standing Twisting Walking

Do you have any of the following?

Swelling Bruising Numbness Tingling

Is the problem getting better or worse?

Better Worse No Change

Pain Frequency: Intermittent Constant Activity Related Worse in AM Worse in PM

Previous treatment for this problem? *(circle what applies)* Bracing Medications Physical Therapy Injections Surgery Chiropractor Cane/Crutches Other: __________________

Name: ______________________________

DOB: ______________________

SPORTS MEDICINE & JOINT REPLACEMENT SPECIALISTS

Consent to Treatment and Payment Authorization

I hereby give my consent to the physicians and other clinical personnel of for Sports Medicine & Joint Replacement Specialists, Corp. for the evaluation and treatment of the conditions for which I present in their offices.

I hereby authorize the office of Sports Medicine & Joint Replacement Specialists, Corp. to release any medical information required to permit payment directly to them for services rendered.

I authorize Sports Medicine & Joint Replacement Specialists, Corp. to release information related to my condition to the applicable worker's compensation carrier, auto insurance carrier, or my personal health insurance carriers as necessary based on the type and place of injury.

I recognize and accept the responsibility for services rendered regardless of insurance coverage; including but is not limited to, co-insurance, co-payment, deductible, and non-covered services.

Sports Medicine & Joint Replacement Specialists Corp. will not accept any attorney's letter of protection. All charges for my care are ultimately my responsibility to pay in full, within 60 days of services rendered.

Patient Consent for Use and Disclosure of Protected Health Information

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication.

You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

*If **YES**, please name the family members allowed:* ____

Patient Name: (Printed)_______________________________ Signature: ______________________________________

(If not the patient state your relationship to the patient): _______________________________

Today's Date: _______________________________