West Sports Medicine and Orthopaedics

Patient Registration Form

Patient's Name (Last) _____ (First) _____ (M.I.) _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Other

Social Security Number: _____ Sex: ☐Female ☐Male DOB: _____

Phone #: (Home) _____ (Cell) _____ (Work) _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Primary Language: _____

Race: ☐White ☐African American ☐Native American ☐Asian ☐American Indian ☐Other

Employment Status: ☐Employed ☐Unemployed ☐Student ☐Retired

Name of Employer: _____ Occupation _____

Emergency Contact Name: _____ Phone: _____

Emergency Contact Relationship to Patient: _____

Referring Provider Name: _____ Pharmacy: _____

Responsible Party Information

Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Relationship to the Patient: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured _____

Insured DOB: _____ Insured SS#: _____ ☐Male ☐Female

Insured Employer: _____

I agree that the above information supplied on this form is accurate to the best of my knowledge

Patient (Responsible Party) Signature: _____ Date: _____

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Patient Consent Form

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures / tests
- Performance of other medically accepted laboratory test

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **West Sports Medicine & Orthopaedics** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **West Sports Medicine & Orthopaedics** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the *Notice of Privacy Practices.*

A photocopy of this consent shall be considered as valid as the original.

Medicare Patients: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **West Sports Medicine & Orthopaedics.**

I acknowledge that I have been given the West Sports Medicine & Orthopaedics Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. **Patient Initials:** _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient (Responsibly Party) Signature: _____ Date: _____

West Sports Medicine and Orthopaedics

Consent to release medical records

I give **West Sports Medicine & Orthopaedics** and/or members of the office staff to release any or all medical information to specified person(s) other than you. ☐YES ☐NO

If yes, please specify to whom your medical information may be released to.

Authorized Person(s) _____ Relationship to you _____

_____ _____

_____ _____

_____ _____

_____ _____

I understand that as part of my continuing healthcare my physician maintains medical records in his/her office which contain my health history, symptoms, examination test results, diagnoses and treatment plans to be used as a basis for planning my care and treatment. This information may be released to my other physician(s) and/or healthcare provider(s).

I understand that I have the right to request restrictions as to how my medical records may be used or disclosed.

I understand that my physician keeps on the premises a copy of the " Notice of Privacy Practices for Protected Health Information" which provides a more complete description of the uses and disclosures of my medical records, and that I have been provided an opportunity to review this document prior to signing this consent. A written copy will be provided to me upon request.

I understand that my physician has the right to change this policy and that I will be notified in writing prior to any changes taking effect.

I understand that this document is a part of my permanent medical record, and that I may make changes regarding the disclosure of my health information as any time. I will notify West Sports Medicine & Orthopaedics of these changes in writing.

Patient Signature: _____ Date: _____

West Sports Medicine
and Orthopaedics

Financial Statement

Patients Name: _____ DOB: _____

I agree to be personally responsible for any balance due on my account that is not covered by my insurance. Further, should my account be placed in collections, I will be responsible for any collection fees, attorney fees or court costs.

Patient Signature (Responsible Party): _____ Date: _____

West Sports Medicine and Orthopaedics

DAVID A WEST, D.O.

NEW PATIENT HISTORY FORM

Name: _____ DOB: _____ AGE: _____ Today's Date: _____

Employer: _____ Occupation: _____

Where you referred to our office by a physician? Yes ☐ No ☐ Whom? _____

Who is your **Primary Care Physician**? _____

Pharmacy Name, Location, Phone # _____

Chief Complaint: _____

_____ Date symptoms started: _____

Is this a work related? Yes ☐ No ☐ Is this a sports injury? Yes ☐ No ☐ If yes, what sport? _____

Is this an injury from a motor vehicle accident? Yes ☐ No ☐ If yes, when? _____ what state? _____

Do you plan legal action regarding your injury? Yes ☐ No ☐

Have you retained an attorney? Yes ☐ No ☐ If yes, who? _____

List dates of work missed: _____

Have you received any treatment for <u>this</u> problem? Yes ☐ No ☐ If yes, what treatment have you received?

☐ X-rays ☐ MRI ☐ CT/Myelogram ☐ Bone Density Test ☐ Surgery ☐ Physical Therapy ☐ EMG ☐ Chiropractic

☐ Pain Management ☐ Injections ☐ Other _____

Annual Medical History Information – Check all of your prior and current illnesses or conditions

☐ High blood pressure
☐ Heart Attack - Year: _____
☐ Heart Disease
☐ High Cholesterol
☐ Diabetes (Pills / Insulin)
☐ Kidney Disease
☐ Kidney Stones
☐ Blood Clots
☐ Ulcers/Stomach problems
☐ Gastric Reflux
☐ Thyroid Disease
☐ Other _____

☐ Stroke - Year: _____
☐ Asthma
☐ Emphysema
☐ COPD
☐ Tuberculosis
☐ Cancer
location: _____
☐ Seizures
☐ Migraines
☐ Chronic Headaches
☐ Hepatitis _____
☐ Neuropathy

☐ Rheumatoid Arthritis
☐ Osteoarthritis
☐ Osteoporosis
☐ HIV/AIDS
☐ Anxiety
☐ Depression
☐ Bipolar
☐ Addiction (alcohol, drugs)
☐ Impotence (Males)
☐ Current Pregnancy (Females) _____
☐ Date of last period _____
☐ Sleep Apnea

Height: _____ Weight: _____ Flu Vaccine: (year) _____ Pneumonia Vaccine: (year) _____

Social History – Check all that apply

Marital status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Tobacco use: ☐None ☐Packs per day _____x _____years ☐Quit smoking (date) _____

Alcohol use: ☐None ☐Rarely ☐Socially ☐Daily

Recreational drug use: ☐None ☐Yes, what drug _____

Education level: ☐GED ☐High School ☐Some College ☐College Graduate ☐Post Graduate ☐Military

Family History (mother, father, siblings, grandparents) – Check all that apply

☐High Blood Pressure ☐Diabetes ☐Osteoporosis ☐Arthritis ☐Back Problems

☐Stroke ☐Heart Attack ☐Mental Illness ☐Scoliosis ☐Other _____

Medication Allergies -

Surgical History – List all surgeries, include approximate date and surgeon.

Surgery	Date	Surgeon

Current Medication List

Have you ever had problems with anesthesia? ☐NO ☐YES

Have you ever had problems with blood transfusions? ☐NO ☐YES

I acknowledge that all of the information above is complete and accurate. I hereby authorize West Sports Medicine & Orthopaedics physicians and staff to perform upon me or the above named patient an exam, x-rays, and/or tests required for the treatment of my Orthopaedic illness or injury.

Signature: _____ **Date:** _____