

PATIENT MEDICAL HISTORY

TODAY'S DATE: _____

NAME: _____ AGE: _____ SEX: M F

HEIGHT: _____ WEIGHT: _____

MARITAL STATUS: Married Single Other _____ Right-handed Left-handed

CHIEF COMPLAINT: _____

REFERRING PHYSICIAN: _____

Briefly Describe Your Injury: _____

In non-injury, how long have you had chief complaint? _____

Was this an injury? NO YES If Yes, Date of Injury: _____

Were you at work? NO YES

Motor vehicle related injury? NO YES

If so, do you have an attorney? NO YES

Name of Attorney _____

PAIN AND SYMPTOMS OF CURRENT CHIEF COMPLAINT

- | | | |
|---|--|--|
| <input type="checkbox"/> NUMBNESS/TINGLING
Describe: _____ | <input type="checkbox"/> SWELLING
<input type="checkbox"/> CATCHING/LOCKING
<input type="checkbox"/> PAIN CLIMBING STAIRS
<input type="checkbox"/> POPPING/CLICKING
<input type="checkbox"/> LIMITED RANGE OF MOTION
<input type="checkbox"/> GIVING WAY EPISODES | <input type="checkbox"/> PREDOMINANTLY LEG PAIN
<input type="checkbox"/> PREDOMINANTLY BACK PAIN
<input type="checkbox"/> BOWEL/BLADDER CHANGES
<input type="checkbox"/> PAIN WHILE SITTING
<input type="checkbox"/> PAIN WHILE STANDING
<input type="checkbox"/> PAIN WHILE LAYING DOWN
<input type="checkbox"/> WEAKNESS |
| <input type="checkbox"/> RADIATING PAIN
Describe: _____ | <input type="checkbox"/> PAIN WHILE WALKING
<input type="checkbox"/> TROUBLE SLEEPING | |

TREATMENT YOU HAVE HAD FOR CURRENT INJURY

- | | | |
|--|--|--|
| <input type="checkbox"/> PAIN MEDICATION
<input type="checkbox"/> ANTI-INFLAMMATORY MEDS
<input type="checkbox"/> MUSCLE RELAXERS
<input type="checkbox"/> ORAL STEROIDS
<input type="checkbox"/> EPIDURAL STEROID
INJECTIONS
<input type="checkbox"/> NERVE ROOT BLOCKS | <input type="checkbox"/> CHIROPRACTIC TREATMENT
<input type="checkbox"/> SPLINTING/BRACING
<input type="checkbox"/> CASTING
<input type="checkbox"/> REST
<input type="checkbox"/> PHYSICAL THERAPY
<input type="checkbox"/> CORTISONE INJECTIONS | <input type="checkbox"/> MRI
<input type="checkbox"/> X-RAYS
<input type="checkbox"/> CT/MYELOGRAM
<input type="checkbox"/> DISCOGRAM
<input type="checkbox"/> BONE SCAN |
|--|--|--|

PAST MEDICAL HISTORY

- | | | |
|---|--|---|
| <input type="checkbox"/> ASTHMA
<input type="checkbox"/> FAINTING SPELLS
<input type="checkbox"/> HEART TROUBLE
Describe _____
Cardiologist _____ | <input type="checkbox"/> ARTHRITIS
<input type="checkbox"/> LUPUS
<input type="checkbox"/> BLEEDING DISORDER
<input type="checkbox"/> ALCOHOLISM
<input type="checkbox"/> STOMACH ULCERS
<input type="checkbox"/> HEPATITIS A, B, OR C
<input type="checkbox"/> MIGRAINE HEADACHES
OTHER: _____ | <input type="checkbox"/> DIABETES
<input type="checkbox"/> HEART ATTACK (AGE ____)
<input type="checkbox"/> CONVULSIONS
<input type="checkbox"/> STROKE
<input type="checkbox"/> EPILEPSY
<input type="checkbox"/> EMPHYSEMA
<input type="checkbox"/> HIV INFECTION |
| <input type="checkbox"/> CANCER
<input type="checkbox"/> HIGH BLOOD PRESSURE
<input type="checkbox"/> TUBERCULOSIS | | |

LIST ALL SURGERIES YOU HAVE HAD (please list all surgical procedures you have had)

CURRENT MEDICATION YOU ARE TAKING (please list all medications you are taking)

DRUG ALLERGIES (List all medication allergies) OR LIST NO KNOWN DRUG ALLERGIES

SOCIAL HISTORY

DO YOU USE TOBACCO PRODUCTS (cigarettes/chewing tobacco/cigars) NO YES
DO YOU CONSUME ALCOHOLIC BEVERAGES? NO YES
OCCUPATION: _____ ARE YOU CURRENTLY WORKING? NO YES

FAMILY MEDICAL HISTORY

HYPERTENSION HEART DISEASE LUNG DISEASE
 ARTHRITIS DIABETES CANCER

REVIEW OF SYSTEMS (Please check all that apply)

FATIGUE NAUSEA/VOMITING ANXIETY
 NIGHT SWEATS INCONTINENCE DEPRESSION
 WEIGHT LOSS/GAIN DIARRHEA HISTORY OF GOUT
 LOSS OF APPETITE CONSTIPATION BLEEDING DISORDER
 TROUBLE SLEEPING CHEST PAIN SLEEP APNEA
 HEADACHES SHORTNESS OF BREATH HISTORY OF SEIZURES
 DIZZINESS PREVIOUS STROKE PARALYSIS
 BLURRED VISION VISION CORRECTION OPEN WOUNDS/LESIONS

PATIENT SIGNATURE: _____ DATE: _____

PATIENT INFORMATION

Name: _____
Last First Middle

Address: _____
Street Apt # City State Zip

Home #: () _____ Cell #: () _____ Email: _____

Social Security #: _____ DOB: _____ Age: _____

Sex: M F Marital Status: Single Married Divorced

Employer: _____ Work #: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Relationship: _____

Address: _____

DOB: _____ Social Security #: _____

INSURANCE INFORMATION

Primary Insurance: _____

Insurance ID: _____ Group #: _____

Policy Holder: _____ Relationship to Patient: _____

DOB: _____ Social Security #: _____

Address of Policy Holder: _____

Secondary Insurance: _____

Insurance ID: _____ Group #: _____

Policy Holder: _____ Relationship to Patient: _____

DOB: _____ Social Security #: _____

Address of Policy Holder: _____

PRIMARY CARE/REFERRING PHYSICIAN

Primary Care Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Address: _____

How did you hear about us: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
Home #: _____ Cell #: _____ Work #: _____

I hereby consent for Westlake Orthopaedics to discuss my treatment, and/or schedule/cancel appointments with: (If this is not filled out, we will only be able to speak to you directly).

Name: _____ Relationship: _____

AUTHORIZATIONS AND ACKNOWLEDGEMENT OF POLICIES AND PROCEDURES

If you wish to have a copy of these policies, please contact our front desk.

FINANCIAL RESPONSIBILITY. ASSIGNMENT OF BENEFITS. AUTHORIZATIONS TO RELEASE INFORMATION.

I hereby authorize the physician to release information in connection with my treatment to my insurance company, my employer, their representative, or referring physician, at such time as information is requested. I authorize assignment of benefits to my physician.

I UNDERSTAND AND WILL ASSUME FINANCIAL RESPONSIBILITY FOR PAYMENT IN FULL OF THE DURABLE MEDICAL EQUIPMENT USED INVOLVING MY SURGERY. IF MY INSURANCE IS BILLED AND DENIES THIS PAYMENT/SERVICE FOR PAYMENT, I WILL BE RESPONSIBLE FOR PAYMENT IN FULL.

OFFICE CANCELLATION POLICY

Our office requires a 24 hour cancellation notice for appointments. If you fail to do so there will be a 25.00 charge to your account and the insurance cannot be billed for this charge.

OFFICE POLICY ON STANDARD INSURANCE AND MANAGED CARE INSURERS

I hereby acknowledge having received and reviewed the policies concerning managed care programs, self pay, Medicare, auto-accidents, and workers compensation.

POLICIES AND FEES FOR MEDICAL RECORDS, XRAY DUPLICATION, DISABILITY FORMS AND CO-PAYS

When medical records are requested, there will be a \$25.00 fee and a 5-7 day turn around time for processing. I hereby acknowledge having received and reviewed the policies: The above office policies are set in accordance with Texas Medical Board regulations and offices in this area.

PROTECTED HEALTH INFORMATION

I hereby acknowledge having reviewed Westlake Orthopaedics Spine and Sports Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to a copy of this document upon request.

CONSENT FOR TREATMENT

I do hereby consent to necessary examinations, procedures, and/or treatment by the physician, his/her assistants, and designees as is necessary in his/her judgment.

Signature of Patient or Legal Guardian: _____

Date: _____