

Professional Athletic Orthopedics, LLC
or
Kirkwood Diagnostic & Orthopedic Associates, LLC

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I.: _____
Address: _____ City: _____ State/Zip: _____
Home Phone: _____ Cell: _____ Marital Status: _____
Social Security #: _____ Date of Birth: _____ Gender: _____
Employer/Occup: _____ Employer Phone: _____ Email: _____
Race: ___ Black ___ White ___ Asian ___ American Indian ___ Native Hawaiian or Other Pacific Islander ___ Other
Ethnicity: ___ Hispanic/Latino ___ Not Hispanic/Latino Preferred Language _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: _____

HEALTH INSURANCE INFORMATION - A Copy of Your Health Insurance Card(s) is Required

<u>PRIMARY Coverage</u>	
Insurance Company:	_____
Subscriber/Card Holder/Policy Owner:	_____
Subscriber's Date of Birth:	_____
Subscriber's Relationship to Patient:	_____
<u>SECONDARY Coverage</u>	
Insurance Company:	_____
Subscriber/Card Holder/Policy Owner:	_____
Subscriber's Date of Birth:	_____
Subscriber's Relationship to Patient:	_____

Primary Care Physician: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

How did you hear about our office: _____

Pharmacy Name: _____ **Phone:** _____

Mail Order Pharmacy: _____ **Phone:** _____

AUTHORIZATION

I hereby authorize this office to furnish information to insurance carriers including Medicare and Medicaid concerning this illness/accident and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance or workers compensation. I hereby authorize photocopies of this authorization form to be valid as the original. I consent to disclosure of my medical information to outside agencies for the purpose of providing healthcare services to me. If I fail to obtain a referral, I understand that I am financially responsible. I acknowledge that I have received the mandatory information regarding "Notice of Privacy Practices." (HIPAA)

X SIGNATURE _____ **Date** _____

AUTHORIZATION TO RELEASE INFORMATION (Your Signature Is Required)

Do You Authorize Another Person To Receive Your Medical Information? Yes No

If YES, Who: _____ Relationship to Patient _____

Do You Authorize Another Person To Receive Your Billing Information? Yes No

If YES, Who: _____ Relationship to Patient _____

Do You Authorize Professional Athletic Orthopedics, LLC or Kirkwood Diagnostic & Orthopedic Associates, LLC To Leave Patient Test Results on an Answering Machine or Voice Mail: Yes No

If YES, at which phone number(s)? _____

Date _____

Is visit due to a work related injury? Yes No Is visit due to an automobile accident? Yes No

Name _____

Patient's Height: _____ Patient's Weight: _____

Age _____

REASON FOR TODAY'S VISIT

Date symptoms began: _____ Body Part: _____ (RT/LT/Both)

DOB _____

Describe problem: _____

If injured, what makes it worse? _____

If injured, what makes it better? _____

Have you had similar symptoms prior to this visit? _____

Have you seen another physician for this problem? _____

If so, which physician: _____ Dates of care: _____

Was surgery performed? _____ Date: _____ Did the problem resolve? _____

Do you exercise? Yes No Brief description of activities _____

PAST MEDICAL HISTORY

	No	Yes		No	Yes		No	Yes
Stroke or TIA			Paralysis			Emphysema		
Heart Attack			Numbness (Hands/Feet)			Asthma		
Heart Murmur			Athrits DJD			Tuberculosis		
Mitial Valve Prolapse			Head or Spine Injury			Diabetes		
High Blood Pressure			Back Pain or Injury			Cancer		
High Cholesterol			Ulcers			Type of Cancer:		
DVT or Blood Clots			Hypothyroid			COPD		
Bleeding Tendencies			Epilepsy			HIV		
Anemia			Hepatitis - What Type			Kidney Disease		
Skin Cancer			Seizures			Seasonal Allergies		
Sleep Apnea			Asthma					

FAMILY HISTORY (Check all that apply.)

Diabetes Heart Disease Stroke High Blood Pressure
 Cancer Kidney Disease Anesthesia Problems Other _____

PAST SURGICAL HISTORY

Surgeries/Hospitalizations:	
1.	5.
2.	6.
3.	7.
4.	8.

Have you ever had a problem with Anesthesia? Yes No Check box if list continues

Explain: _____

Do you require antibiotics prior to dental/medical procedures? Yes No

SOCIAL HISTORY

Tobacco Use: No Yes, Packs per day? _____ for _____ Years Stopped - When? _____
 Daily Alcohol Use: No Yes, Amount? _____ Caffeine: No Yes, Amount? _____

ALLERGIES/TYPE OF REACTION

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VACCINATIONS

Date of last tetanus shot _____

REVIEW OF SYSTEMS

	No	Yes		No	Yes
Weight Loss			Vomiting of Blood		
Fever and/or Chills			Any Change in Bowel Habits		
Double Vision			Heartburn		
Loss of Vision			Difficult Urination		
Loss of Hearing			Pain or Burning on Urination		
Severe Nose Bleeds			Blood in Urine		
Hoarseness			Frequent Urge to Empty Bladder		
Frequent Sore Throats			Loss of Urine when Laughing, Coughing, etc.		
Shortness of Breath with Exertion			Weakness		
Swelling of Feet or Ankles			Frequent Itching		
Sudden Changes in Rate of Heart Beat			Rashes		
Pain or Pressure in Chest with Exertion			Numbness/Tingling		
Awakened at Night Short of Breath			Memory Loss		
Chronic Cough			Balance Problems		
Coughing up Blood			Do you Worry a Lot?		
Frequent Chest or Bronchial Infections			Are you a Nervous Person?		
Nausea or Vomiting			Are you Frequently Unhappy or Depressed?		
			Excessively Thirsty, Hot, Cold, Sleepy		

