SOUTHWEST SPORTS MEDICINE

Patient:

Patient's Name: _____

Home Address: _____

City: _____

State:_____ Zip:_____

Home phone: (____)_____

Cell phone: (____)_____

Work phone: (____)_____

Date of Birth: _____ Age: _____

Social Security No.: _____

Who referred you to this practice? _____

Name of Primary Care Physician: _____

Did your injury occur at work? Yes No

Email address:_____

Sex: Male Female

Marital Status: Married Single Divorced Widowed

Employment Status: Employed Unemployed Retired Student

Patient's Employer/School:_____

IF MARRIED: Spouse's Name: _____

Phone: (____)_____

Preferred Pharmacy : _____

Emergency Contact(other than spouse):

Name: _____Relationship:_____

Ph: _____

Name: _____Relationship:_____

Ph: _____

Patients under 18 need a Guarantor (who is responsible for the bills and where they will be sent):

Name: _____

Address: _____

City: _____

State: _____Zip:_____

Sex: Male Female

Date of Birth: _____

Relationship to Patient: _____

Phone No.:_____

In order for us to file your insurance, the following MUST be complete. "INSURED" is who carries for the coverage.

Primary Insurance Information:

Insurance Company Name:_____ Id No.: _____Group No. :_____

Primary Insured Name: _____

Primary Insured address : _____

City:_____

State: _____ Zip:_____

Phone No.:_____

Sex: Male Female

Insured's Date of Birth: _____

Insured's Social Security No.: _____

Relationship to Patient: _____

Insured's Employer: _____

Secondary Insurance Information:

Insurance Company Name_____ Id No.: _____Group No. :_____

Primary Insured Name _____

Primary Insured address: _____

City: _____

State: _____Zip:_____

Phone No.: _____

Sex: Male Female

Insured's Date of Birth: _____

Insured's Social Security No.: _____

Relationship to Patient: _____

Insured's Employer: _____

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Review of Systems

Patient Name:_____ Date: _____

REVIEW OF SYSTEMS: If you have had any recent trouble with the following issues, check the problem(s) listed. If you **do not** have any of the problem selections, check the "**No Problem**" box.

GENERAL: ☐ Fever ☐ Fatigue	☐ **No Problem**
SKIN: ☐ Rashes ☐ Changes in skin, hair, or nails	☐ **No Problem**
EYES: ☐ Pain ☐ Redness ☐ Blurring vision	☐ **No Problem**
EARS: ☐ Earache ☐ Hearing loss	☐ **No Problem**
NOSE: ☐ Post nasal drip ☐ Sinus pain	☐ **No Problem**
THROAT: ☐ Pain ☐ Hoarseness ☐ Trouble swallowing	☐ **No Problem**
LUNGS: ☐ Cough ☐ Wheezing ☐ Phlegm/Sputum ☐ Shortness of breath	☐ **No Problem**
HEART & CIRCULATION: ☐ Chest pain, tightness, or pressure ☐ Irregular heart beat	☐ **No Problem**
URINARY: ☐ Frequency or painful urinating ☐ Blood in urine	☐ **No Problem**
STOMACH, INTESTINES & COLON: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation	☐ **No Problem**
MUSCLES, JOINTS & BONES: ☐ Joint swelling/redness ☐ Muscle pains/cramps	☐ **No Problem**
NERVOUS SYSTEM: ☐ Fainting ☐ Headaches	☐ **No Problem**
BLOOD/ALLERGIES: ☐ Anemia ☐ Easy bruising or bleeding	☐ **No Problem**
PSYCHOLOGICAL: ☐ Loss of interest in activities that are normally enjoyed	☐ **No Problem**

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Patient Medical Information

Patient Name:_____

Orthopedic History

Please tell us why you have come to the doctor today. Include whether it is the right or left side. Is this an injury? If so, please give the date and circumstance of the injury.

_____

_____

Do you have any previous history of problems involving this extremity? Yes No

Have you received any treatment for this problem? Yes No If yes, what? _____

Medical History

Present medications (Please list prescription, over-the-counter, vitamins and herbal supplements):

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Are you allergic to:

Penicillin? Yes No

Codeine? Yes No

Sulfa Drugs? Yes No

Others: _____

Please list any hospitalizations or surgeries you have had:

_____

_____

_____

_____

Do you have any of the following medical conditions? (circle all that apply)

Asthma	Cancer	Heart Problems	HIV	Psychiatric problems
AIDS/at risk	Diabetes	Hemophilia	Keloids(excessive scarring)	Rheumatoid arthritis
Bleeding Tendency	Duodenal Ulcer	Hepatitis	Kidney/Bladder problems	Tuberculosis
Blood Disorder	Epilepsy	High blood pressure	Nose bleeds	

If you circled psychiatric problems, have you visited with a psychiatrist? Yes No

List your daily consumption of: Alcohol: _____ Tobacco: _____

Signature:_____ Date:_____

Note: If the patient is a minor, parent or guardian must sign.

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SPORTS MEDICINE

Fees for services are due and payable at the time service is rendered. Southwest Sports Medicine and Orthopaedics will file charges with your insurance company, however, patients who carry health insurance should remember that professional services are rendered and charged to the patient and not the insurance company.

I hereby authorize Southwest Sports Medicine and Orthopaedics and its doctors to furnish medical information to my insurance carrier concerning my and/or my dependents' illness and treatments. A photo copy of this assignment and release shall be effective and valid as an original for the duration of my treatment. I assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I understand and agree that, regardless of my insurance status, I am ultimately responsible for any fees for professional services rendered.

I hereby authorize Southwest Sports Medicine and Orthopaedics and its doctors to administer in this office such medications and treatments as are necessary on the basis of findings in my case. I also consent to the administrations of such anesthetics as are necessary.

I acknowledge that I have been made aware and offered a copy of Southwest Sports Medicine and Orthopaedics privacy policy relating to the handling of my private health information.

I certify that the information on this form is true and correct to the best of my knowledge and that I will notify Southwest Sports Medicine and Orthopaedics of any changes.

I acknowledge that the insurance information is correct. I acknowledge that my injury ***is not related to work***. (If your injury is a work- related injury you must contact your employer and have them set up an appointment with a Texas Worker's Compensation doctor. You may ***not*** keep this appointment, give us your personal insurance and decide at a later date that what you are being seen for today is a work- related injury.)

X_____ Date: _____

Patient/Guarantor's Signature

SOUTHWEST SPORTS MEDICINE

School Athletic Program

Disclosure Authorization for Release of Protected Health Information

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In an effort to provide your child with the best ongoing medical care we would like to ask your permission to share medical information with your child's coaches/trainers. We feel this would allow the best plan of care for your child. This will allow us to have discussions regarding injuries, interventions and proper exercise programs for your child's particular injury. In the interest of time, this agreement would remain in effect until the end of the school year. If you at any time wish to revoke this agreement you may call us or write us a note asking that we not share information with the athletic personnel.

Thank you.

_____ _____

Student's Name School

Yes, you may discuss my child's plan of care and medical information with his coach/trainer.

_____ _____

Parent Signature Date

No, at this time I wish to decline and do not want anyone to discuss my child's injury/medical condition with coaches/trainers.

_____ _____

Parent Signature Date