SOUTHWEST SPORTS MEDICINE

Patient:

Patient's Name: _____ Email address:_____

Home Address: _____ Sex: Male Female

City: _____ Marital Status: Married Single Divorced Widowed

State:_____ Zip:_____ Employment Status: Employed Unemployed Retired Student

Home phone: (____)_____ Patient's Employer/School:_____

Cell phone: (____)_____ IF MARRIED: Spouse's Name: _____

Work phone: (____)_____ Phone: (____)_____

Date of Birth: _____ Age: _____ Preferred Pharmacy : _____

Social Security No.: _____ ***Emergency Contact(other than spouse):***

Who referred you to this practice? _____ Name: _____Relationship:_____

Name of Primary Care Physician: _____ Ph: _____

Did your injury occur at work? Yes No Name: _____Relationship:_____

Ph: _____

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

Name: _____ Sex: Male Female

Address: _____ Date of Birth: _____

City: _____ Relationship to Patient: _____

State: _____Zip:_____ 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: _____ Sex: Male Female

Primary Insured address : _____ Insured's Date of Birth: _____

City:_____ Insured's Social Security No.: _____

State: _____ Zip:_____ Relationship to Patient: _____

Phone No.:_____ Insured's Employer: _____

Secondary Insurance Information:

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

Primary Insured Name _____ Sex: Male Female

Primary Insured address: _____ Insured's Date of Birth: _____

City: _____ Insured's Social Security No.: _____

State: _____Zip:_____ Relationship to Patient: _____

Phone No.: _____ Insured's Employer: _____

Review of Systems & Patient Medical Information

Patient Name: _____ DOB:_____ Height/Weight: _____/_____

REVIEW OF SYSTEMS: If you have had recent trouble with the following issues, check the problem(s) list or "**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**

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

Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____

Please list any medication allergies:

_____
_____

Please list any surgeries you have had:

_____
_____

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

Anesthetic Complications	Clotting Disorder	Gout	Hyperthyroidism	Rheumatoid Arthritis
Arthritis	Diabetes	Heart Disease	Hypothyroidism	Scoliosis
Cancer	DVT	Hyperlipidemia	Lung Disease	
Chest Pain	Fractures	Hypertension	Osteoporosis	

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

Signature of patient/parent/guardian_____ Date: _____

Provider Signature_____ Date _____