

Name:  
 DOB:  
 Chart:  
 Age:  
 Date:



### PATIENT INFORMATION

(Please Print)

Patient Name:		Home Phone:	
Patient Date of Birth:	Age:	Cell Phone:	
Patient Social Security #:	Sex:	Consent to call? <input type="checkbox"/> Yes <input type="checkbox"/> No    Consent to text? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address:		Work Phone:	
City:	State:	Zip:	Patient or Parent email:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married		Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese	
<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		<input type="checkbox"/> Japanese <input type="checkbox"/> Portuguese	
Spouse Name:		Race: <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black	
Spouse Social Security #:		<input type="checkbox"/> White <input type="checkbox"/> Other	
Spouse's Date of Birth:		Ethnicity: <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Other:	
Spouse's Employer:		Patient Employer:	
Employer Address:		Employer Address:	
City:	State:	Zip:	City:    State:    Zip:
Employer Phone:		Occupation:	

### ALTERNATE OR EMERGENCY CONTACT INFORMATION

Name:	Home Phone:
Address:	Cell Phone:
City:    State:    Zip:	Relationship to Patient:

### REASON FOR TODAY'S VISIT

Date of Injury or Pain Onset	Was this an Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sports Related Injury?    If yes, School Name/Phone <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Related? <input type="checkbox"/> Yes <input type="checkbox"/> No
What body part are we seeing you for?:			
Describe How Injury Happened:			
<b>**Work Related Injuries Require Prior Approval**</b>			

### PHYSICIAN AND INSURANCE INFORMATION

Primary Care Physician or Referring Physician:			
Preferred In-Network Hospital: <input type="checkbox"/> JMCGRH <input type="checkbox"/> Tennova-Regional <input type="checkbox"/> Henry Co. Medical Center			
Primary Insurance Co:		Policy #:	Group #:
Policy Holder Name:		Social Security #:	
Relationship to Patient:		Date of Birth:	
Co-Pay Amount (if applicable):		Employer:	
Secondary Insurance Co:		Policy #:	Group #:
Policy Holder Name:		Social Security #:	
Relationship to Patient:		Date of Birth:	
Co-Pay Amount (if applicable):		Employer:	

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<b>GUARANTOR INFORMATION</b>			
(Person responsible for the Account if Other Than Patient)			
Name:		Relationship to Patient:	
Address:		Date of Birth:	
City:	State:	Zip:	Social Security Number:
Employer:		Home Phone:	
Employer Address:		Work Phone:	
City:	State:	Zip:	Does Patient live with Guarantor?    Y    N    (circle)

**Consent for Medical Treatment**

           **Initial**    I authorize West Tennessee Bone & Joint Clinic physicians and personnel to render medical treatment and evaluation needed. I further authorize order of x-rays, injections, casting or other diagnostic tests and treatment that may be necessary.

**Consent for Release of Medical Information**

           **Initial**    I understand that I have rights regarding my protected health information. These rights are governed by the Health Insurance Portability and Accountability Act of 1996. (HIPAA) I have been informed, and given the opportunity to review and secure a copy of the Clinic's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information.

I hereby authorize the release and disclosure of my protected health information for treatment or payment for health care operations. I understand that any and all records concerning my personal and medical history are the confidential property of West Tennessee Bone & Joint Clinic, P.C.

I agree that West Tennessee Bone & Joint Clinic may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

I agree that by providing my email address I am giving consent for West Tennessee Bone & Joint Clinic to set me up for a patient portal account. I also agree that by providing my cell phone number I am giving consent for West Tennessee Bone & Joint Clinic to contact me by this phone number.

You may restrict the individuals or organizations to which your health care information is released and you may revoke your authorization to us at any time, however, your revocation must be in writing and delivered to our address.

**Consent for Financial Responsibility**

           **Initial**    My insurance policy is a contract between myself and my insurance carrier. I am ultimately responsible for payment-in-full for all medical services provided to me. I acknowledge full financial responsibility for services rendered by West Tennessee Bone & Joint Clinic, P.C. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements are made prior to treatment. I agree to pay all collection and attorney fees, if applicable, in the event of default of payment of charges. I assign benefits to and authorize direct payment to West Tennessee Bone & Joint Clinic of which it is entitled. This also includes proceeds and benefits accruing under any settlement, structure or otherwise, or awarded in judgement for personal injuries caused by a third party for payment of services rendered by West Tennessee Bone & Joint Clinic. I agree to pay for all charges not paid pursuant to this agreement. I agree, in order for West Tennessee Bone & Joint Clinic and/or any of its Business Associates to service my account or to collect any amount I may owe, West Tennessee Bone & Joint Clinic and/or any of its Business Associates may contact me at any telephone number associated with my account, including cellular numbers, which could result in charges to me. I may also be contacted by text message or e-mail, using only e-mail address I provide. Methods of contact may include using prerecorded/artificial voice messages and/or use an automatic dialing service.

\_\_\_\_\_  
 Signature of Patient or Responsible Party  
 (Must be 18 years of age or older to sign)

\_\_\_\_\_  
 Date

If you have any questions about this form, please ask the receptionist. Bring completed forms along with photo identification and current insurance cards to the receptionist. This procedure is for your protection against abuse to your insurance.

Name:  
DOB:  
Chart:  
Age:  
Date:

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### ADDITIONAL CONSENT FOR DISCLOSURE OF MEDICAL INFORMATION

West Tennessee Bone & Joint Clinic, P.C. realizes you may wish to have a family member or close friend present at times when health information is discussed with you, such as the time of your office visit, prior to and after surgery, discussing test results etc.

We realize the importance of protecting your privacy. This authorization gives the above Clinic and Staff your consent to disclose personal health information about you to your family, close personal friends, or any person that you identify, as long as the information disclosed to those individuals is relevant to the involvement in your treatment, payment or healthcare operations. The above listed Clinic may notify a family member or another person who is responsible for your care of your location and general health condition.

This form also provides you with the opportunity to choose not to have your health information disclosed to individuals in your care. You must return this form if you wish to opt-out of such disclosures.

Please initial one of the following to indicate your choice regarding such disclosures:

\_\_\_\_\_ **I do not object** to my personal health information being disclosed to a family member, friend, or another individual (et al., physician, trainer, therapist, case manager) involved in my care.

\_\_\_\_\_ **I object** to my personal health information being disclosed to a family member, friend, or another individual involved in my care.

\_\_\_\_\_  
Signature of Patient or Guardian  
(Must be 18 years of age or Older to sign)

\_\_\_\_\_  
Date

Name:  
 DOB:  
 Chart:  
 Age:  
 Date:

**MEDICAL HISTORY**

(Please Print)

Referring Physician:  Chief complaint:

Primary Care Physician:

Current occupation:

Height:  Weight:

Which extremity are we seeing you for?  
 Right  Left  Both

Are you right or left handed?  
 Right  Left

**Tobacco/Alcohol History:**

Never smoker:

Former Smoker:\*\*  \*\*Date Started:

Current some day smoker:\*\*  \*\*Date Stopped:

Current everyday smoker:\*\*  \*\*Packs Per Day:

Do you drink alcohol?  Yes  No  
 Amount:  What kind?

Do you use drugs for recreational use?  Yes  No  
 Amount:  What kind?

**Have you ever been diagnosed with any of the following?**

	Yes	No		Yes	No		Yes	No
Asthma	<input type="text"/>	<input type="text"/>	Rheumatoid Arthritis	<input type="text"/>	<input type="text"/>	HIV/AIDS+	<input type="text"/>	<input type="text"/>
Kidney Disease	<input type="text"/>	<input type="text"/>	Anemia	<input type="text"/>	<input type="text"/>	Osteoarthritis	<input type="text"/>	<input type="text"/>
Lupus	<input type="text"/>	<input type="text"/>	Migraines	<input type="text"/>	<input type="text"/>	Alcoholism	<input type="text"/>	<input type="text"/>
Bleeding Tendencies	<input type="text"/>	<input type="text"/>	Cancer	<input type="text"/>	<input type="text"/>	Sickle Cell Disease	<input type="text"/>	<input type="text"/>
Heart Disease	<input type="text"/>	<input type="text"/>	Diabetes	<input type="text"/>	<input type="text"/>	Colitis	<input type="text"/>	<input type="text"/>
Epilepsy	<input type="text"/>	<input type="text"/>	Goiter	<input type="text"/>	<input type="text"/>	Stroke	<input type="text"/>	<input type="text"/>
High Blood Pressure	<input type="text"/>	<input type="text"/>	Lung Disease	<input type="text"/>	<input type="text"/>	Stomach Ulcers	<input type="text"/>	<input type="text"/>
Polio	<input type="text"/>	<input type="text"/>	Nervous System Disorder	<input type="text"/>	<input type="text"/>	Depression/Anxiety	<input type="text"/>	<input type="text"/>
Hepatitis	<input type="text"/>	<input type="text"/>	Tuberculosis	<input type="text"/>	<input type="text"/>	COPD	<input type="text"/>	<input type="text"/>

Type:  A  B  C

(Chronic Obstructive Pulmonary Disease)

**Past Surgical History:**

List ORTHOPAEDIC surgeries you have had and dates:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 None

List any other surgeries you have had and dates:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 None

**Family History:**

Has anyone in your family had: (check all that apply)

	Father	Mother	Sibling	Child	Other
High Blood Pressure	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Heart Disease	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Diabetes	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Bleeding Problems	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Lung Disease	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cancer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

what type? \_\_\_\_\_  None

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name:  
DOB:  
Chart:  
Age:  
Date:

### Current Medications & Allergies

List any DRUG ALLERGIES you have:  
ex: Penicillin, Sulfa, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  None

List any NON-DRUG ALLERGIES you have:  
ex: Latex, Metals, Pollen, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  None

**Current Medications:** include all prescriptions, over-the-counter medications, herbals, and dietary supplements

Name of Medication	Dosage	How often	Reason for taking

Not Currently Taking any Medications

Preferred Pharmacy Name: \_\_\_\_\_

Pharmacy Phone #: \_\_\_\_\_ Pharmacy Address: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name:  
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**REVIEW OF SYSTEMS & CHIEF COMPLAINT**

REVIEW OF SYSTEMS	CURRENT PROBLEM																																																																																														
<p>Do you currently have any issues with the following?:</p> <p>Yes No <b>Head, Ears, Eyes:</b> Cataracts, glaucoma, glasses, contacts, hearing loss or ringing in your ears?</p> <p>Yes No <b>Nose, Sinuses, Throat, and Mouth:</b> problems with your nose or throat or sleep apnea?</p> <p>Yes No <b>Skin:</b> herpes simplex, rashes, skin infections or changes in skin color?</p> <p>Yes No <b>Breast:</b> Breast cancer, benign growths, or other changes?</p> <p>Yes No <b>Cardiovascular:</b> Chest pain, palpitation, lightheadedness, syncope, murmurs, hypertension, etc?</p> <p>Yes No <b>Respiratory:</b> Asthma, bronchitis, chest pain, emphysema/COPD, shortness of breath, productive cough?</p> <p>Yes No <b>Gastrointestinal:</b> Cirrhosis, Crohns disease, diverticulitis, hernia, reflux, vomiting, ulcers, diarrhea, constipation, etc?</p> <p>Yes No <b>Genito-urinary:</b> blood in urine, frequency, urgency, incontinence, kidney stones, etc? Dialysis? Kidney transplant?</p> <p>Yes No <b>Gynecological:</b> Irregular vaginal bleeding, discharge, pain, etc? Currently pregnant? If pregnant, how many months? _____</p> <p>Yes No <b>Musculoskeletal:</b> Bone cancer, osteoporosis, lupus, rheumatoid arthritis, degenerative joint disease?</p> <p>Yes No <b>Neurological/Psychiatric:</b> Alzheimer's, epilepsy, brain aneurysm, brain surgery, depression, multiple sclerosis, paralysis, Parkinson's, seizures, stroke, or stroke residual, etc.?</p> <p>Yes No <b>Hematologic and Lymphatic:</b> bruising, anemia, bleeding gums, blood transfusion, etc.?</p> <p>Yes No <b>Vascular:</b> anemia, blood clots, hemophilia, varicose veins, pulmonary embolus, sickle cell disease, etc.?</p> <p>Yes No <b>Endocrine:</b> heat or cold intolerance, thyroid problems, abnormal hair growth or loss, skin changes, etc.?</p> <p>Yes No <b>Allergic and Immunologic:</b> any allergic or immunologic problems?</p> <p>Yes No <b>Constitutional:</b> Unexplained fever, weight loss?</p> <p>If you answered Yes to any of the above, please explain:            _____            _____</p>	<p>Please circle all that apply:</p> <p><b>Chief complaint:</b> _____</p> <p><b>Location:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:25%;"></td> <td style="width:25%;">Neck</td> <td style="width:25%;">Upper Back</td> <td style="width:25%;">Lower Back</td> </tr> <tr> <td>Shoulder</td> <td>Arm</td> <td>Elbow</td> <td>Forearm</td> </tr> <tr> <td>Wrist</td> <td>Hand</td> <td>Finger</td> <td>Hip</td> </tr> <tr> <td>Thigh</td> <td>Knee</td> <td>Lower Leg</td> <td>Foot</td> </tr> </table> <p style="text-align: center;">Right                  Left                  Bilateral</p> <p><b>Quality of Pain:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%;"></td> <td style="width:33%;">Intermittent</td> <td style="width:33%;">Ill-defined</td> </tr> <tr> <td>Constant</td> <td>Burning</td> <td>Aching</td> </tr> <tr> <td>Dull</td> <td>Sharp</td> <td>Throbbing</td> </tr> </table> <p><b>Pain:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:10%;"></td> <td style="width:10%;">Left</td> <td style="width:5%;">1</td> <td style="width:5%;">2</td> <td style="width:5%;">3</td> <td style="width:5%;">4</td> <td style="width:5%;">5</td> <td style="width:5%;">6</td> <td style="width:5%;">7</td> <td style="width:5%;">8</td> <td style="width:5%;">9</td> <td style="width:5%;">10</td> </tr> <tr> <td></td> <td>Right</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>6</td> <td>7</td> <td>8</td> <td>9</td> <td>10</td> </tr> </table> <p><b>Onset:</b></p> <p>Gradual                  Sudden without injury</p> <p>Injury: _____</p> <p><b>How long:</b> _____ Days    Weeks                  Months    Years</p> <p><b>Context:</b></p> <p>Improving                  Worsening                  No Change</p> <p><b>Modify Factors:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:60%;">Improved by:</td> <td style="width:10%;">Rest</td> <td style="width:10%;">Activity</td> <td style="width:10%;">Ice/Cold</td> <td style="width:10%;">Heat</td> </tr> <tr> <td>Worsened by:</td> <td>Rest</td> <td>Activity</td> <td>Ice/Cold</td> <td>Heat</td> </tr> </table> <p><b>Associated signs or symptoms:</b> _____            _____            _____</p> <p><b>Prior Evaluations and Date:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:60%;">Other Orthopedic Surgeon</td> <td style="width:20%;">_____</td> <td style="width:20%;">_____</td> </tr> <tr> <td>Family Doctor</td> <td>_____</td> <td>CT Scan _____</td> </tr> <tr> <td>ER/Urgent Care</td> <td>_____</td> <td>Bone Scan _____</td> </tr> <tr> <td>X-ray</td> <td>_____</td> <td>Nerve Test _____</td> </tr> <tr> <td>MRI</td> <td>_____</td> <td>Lab Test _____</td> </tr> </table> <p><b>Prior Treatments and Date Started:</b> _____</p> <table style="width:100%; border: none;"> <tr> <td style="width:30%;">Over the Counter:</td> <td style="width:15%;">Ibuprofen</td> <td style="width:15%;">Aleve</td> <td style="width:15%;">Aspirin</td> </tr> <tr> <td></td> <td>Tylenol</td> <td>Topical</td> <td></td> </tr> <tr> <td>Prescription Meds:</td> <td>Arthritis meds</td> <td>Narcotics</td> <td></td> </tr> <tr> <td></td> <td>Muscle Relaxer</td> <td>Steroids</td> <td></td> </tr> <tr> <td>Physical Therapy</td> <td>Chiropractor</td> <td>Brace</td> <td></td> </tr> </table> <p>How long have you tried the above prior treatment?</p>		Neck	Upper Back	Lower Back	Shoulder	Arm	Elbow	Forearm	Wrist	Hand	Finger	Hip	Thigh	Knee	Lower Leg	Foot		Intermittent	Ill-defined	Constant	Burning	Aching	Dull	Sharp	Throbbing		Left	1	2	3	4	5	6	7	8	9	10		Right	1	2	3	4	5	6	7	8	9	10	Improved by:	Rest	Activity	Ice/Cold	Heat	Worsened by:	Rest	Activity	Ice/Cold	Heat	Other Orthopedic Surgeon	_____	_____	Family Doctor	_____	CT Scan _____	ER/Urgent Care	_____	Bone Scan _____	X-ray	_____	Nerve Test _____	MRI	_____	Lab Test _____	Over the Counter:	Ibuprofen	Aleve	Aspirin		Tylenol	Topical		Prescription Meds:	Arthritis meds	Narcotics			Muscle Relaxer	Steroids		Physical Therapy	Chiropractor	Brace	
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Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_