POWELL ORTHOPEDICS & SPORTS MEDICINE, P. C. ***(PLEASE PRINT AND USE BLUE OR BLACK INK)***

Patient's Name (Last, First, Middle Initial) _____

Responsible Party (if minor) _____

Address _____ City _____ State _____ Zip _____

Primary Phone No. _____ Secondary Phone No. _____

E-mail Address _____

Date of Birth _____ Age _____ Sex M ❑ F ❑ Full Time Student: Y ❑ N ❑ Marital Status: _____

Social Security No. _____ Guarantor's Social Security No. _____

Employed: Y ❑ N ❑ Employer _____ Race _____ Ethnicity _____ Primary Language _____

Emergency Contact & Relationship _____ **Phone No ( )** _____

Primary Care Physician _____ Phone No ( ) _____

Referring Physician _____ Phone No ( ) _____

Pharmacy Name: _____ Phone No ( ) _____

Do you have an advance directive? ❑ Yes ❑ No (If Yes, please circle which one: Living Will, Power of Attorney, Organ Donor)

PRIMARY INSURANCE COMPANY _____

Policy No. _____ Group No. _____ Effective Date _____

Policy Holder's Name _____ Date of Birth _____ Relation to Patient _____

Policy Holder's Employer _____ Policy Holder's Address. _____

SECONDARY INSURANCE COMPANY _____

Policy No. _____ Group No. _____ Effective Date _____

Policy Holder's Name _____ Date of Birth _____ Relation to Patient _____

Policy Holder's Employer _____ Policy Holder's Address _____

CONSENT FOR USE AND DISCLOSURE OF INFORMATION (Please Read and Sign Below)

By signing below, you consent to our use and disclosure of your protected health information for treatment, payment, and health care operation. including but not limited to, review of your complete pharmacy record. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent. I Hereby give my consent for Powell Orthopedics & Sports Medicine, PC, to furnish information to insurance carriers concerning my physical condition and treatments. and I hereby assign to the Physicians all payments for Medical Services rendered to myself or my dependents.

I understand that I am responsible for all fees and finance charges for the above named patient, regardless of Insurance coverage. If, after default. this account is placed in the hands of a collection agency. the undersigned agrees to pay 30% of the unpaid balance as a reasonable collector's fee, together with the additional costs and expenses of collection to the extent permitted by law.

CONSENT FOR USE OF CELL PHONE INFORMATION

I authorize the use of the phone numbers and other contact information I provide, including my cellular number and any future number assigned to me, for calls, texts, emails, to include automated dialers, to contact me regarding my care and my account by medical provider and this medical provider's business associates.

Signature _____ **Date** _____

POWELL ORTHOPEDICS & SPORTS MEDICINE, P.C.

Patient Name: _____ **Date of Birth:** _____

I authorize Powell Orthopedics & Sports Medicine, P.C. to discuss my medical information with the following:

PLEASE LIST THE PERSON'S NAME AND PHONE NUMBER IN ORDER FOR US TO RELEASE ANY INFORMATION

◯ None_____ ◯ Parents_____

◯ Spouse _____ ◯ Mother (only) _____

◯ Father (only)_____ ◯ Guardian _____

◯ Other _____ ◯ Relationship to patient _____

I wish to be contacted by Powell Orthopedics & Sports Medicine, P.C. in the following manner (check all that apply)

◯ Telephone _____
◯ Okay to leave message with detailed information
◯ Leave brief message only
◯ Other (email address) _____

The HIPAA Privacy Act generally requires healthcare providers to take responsible steps to limit the disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses and disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute and adequate record. Uses and disclosures of protected health information may be permitted without prior consent in an emergency.

ACKNOWLEDGMENTS:

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Personal Representative's relationship to the Patient Signature of Witness

_____
PRINT Personal Representative's Name

ACKNOWLEDGMENT OF NOTIFICATION OF PRIVACY PRACTICES (Please Read and Sign Below)
By signing below. you acknowledge the availability of our Notice of Privacy Practices pamphlet. which provides information about how we may use and disclose your protected health information, and is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We reserve the right to change the terms described. and should we do this we will post the changes in all of our offices. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment. payment. or health care operations. We are not required to agree with your restrictions: but if we do. we are bound by our agreement with you.

Signature _____ **Date** _____

POWELL ORTHOPEDICS & SPORTS MEDICINE, P.C.

Date: _____

■ Patient Name (Print) _____ ❑ M ❑ F Age _____

Dominant Hand: ❑ R ❑ L ❑ AMB

■ Who recommended that you visit this office? _____ (Name)

■ ❑ MD ❑ Other Healthcare Provider ❑ Attorney

■ What body part is involved? _____ ❑ R ❑ L

Did you bring X-Rays? ❑ Y ❑ N

■ What is the main reason for this visit? ❑ Pain ❑ Numbness ❑ Weakness ❑ Swelling ❑ Stiffness ❑ Other

■ When did it start? (Please provide the date) _____

■ Where did the injury happen? _____

■ Have you had a problem like this before? ❑ Y ❑ N If so, when and who treated you for this problem:

_____

■ **Is this a WORK RELATED INJURY?** _____

■ **Is this injury related to a MVA (Motor Vehicle Accident)?** _____

Have you had a flu vaccine this year? _____ If so,when and where?_____

Have you ever had a pneumonia shot? _____ If so, when and where? _____

On a scale of 1-10, please rate your pain today?_____ (1= no pain, 10= unimaginable pain)

If you are 65 or older, have you had a fall within the past year?_____

If so how many falls within the past year?_____

Was the fall with or without injury? _____

Patient Name (Print)

Medical History (your health issues)

- ❑ None
- ❑ High blood pressure
- ❑ Heart Disease
- ❑ Diabetes
- ❑ Asthma
- ❑ Thyroid disease
- ❑ Peptic ulcer disease
- ❑ Cancer type _____
- ❑ Stroke year _____
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Other_____

Medication (please list your current medications and any medications you have taken in the past month)
None: ❑

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies to medications/others

- ❑ None
- ❑ Penicillin
- ❑ Sulfa
- ❑ Aspirin
- ❑ Codeine
- ❑ Latex
- ❑ Other _____

Family History
(what runs in your family)
Mother (Alive/Deceased/Unknown)
Father (Alive/Deceased/Unknown)

	Mother/Father
❑ Heart disease	___ ___
❑ High blood pressure	___ ___
❑ Diabetes	___ ___
❑ Cancer type_____	___ ___
❑ Arthritis	___ ___
❑ Other_____	___ ___

Surgical History
(Please list any surgeries you've had in your life)

_____ date_____
_____ date_____
_____ date_____
_____ date_____
_____ date_____
_____ date_____

Social History
Current Occupation: _____
Alcohol: ❑ Yes ❑ No (If yes)
How many? _____
How often? _____
Marital status:
❑ single ❑ married ❑ divorced
❑ widowed ❑ separated
Tobacco Use:
❑ Smoking: ____packs/day
Smokeless/Chew/Dip
Electronis Cigs
Former Smoker (year quit_____)

Are you on blood thinners? ❑ Yes ❑ No
Are you in pain management? ❑ Yes ❑ No (If yes whose care are you under _____)
Do you have a pacemaker and/or stimulator? ❑ Yes ❑ No
Do you have an egg allergy? ❑ Yes ❑ No
Do you currently experience any of the following? (Check all that apply) If none apply, please check here ❑

General
- ❑ weight loss
- ❑ fevers
- ❑ fatigue

Cardiovascular
- ❑ chest pain
- ❑ irregular rhythm
- ❑ heart murmur

Gastrointestinal
- ❑ heartburn w/aspirin
- ❑ stomach ulcers
- ❑ acid relux
- ❑ gastric bypass/sleeve

Musculoskeletal
- ❑ arthritis
- ❑ osteoporosis
- ❑ _____

Neurologic
- ❑ balance problems
- ❑ dizziness
- ❑ weakness
- ❑ headaches
- ❑ seizures
- ❑ numbness/tingling

Eyes
- ❑ glasses
- ❑ contacts
- ❑ glaucoma

Ear/Nose/Throat
- ❑ hearing loss
- ❑ sinus infections

Respiratory
- ❑ shortness of breath
- ❑ sleep apnea
- ❑ COPD/emphysema
- ❑ asthma

Urinary
- ❑ painful urination
- ❑ urinary infections
- ❑ urinary frequency

Skin
- ❑ rash / sores
- ❑ psoriasis

Hematologic
- ❑ bleeding problems
- ❑ blood clots
- ❑ pulm emboli
- ❑ anemia

Immunologic
- ❑ tuberculosis
- ❑ HIV infections
- ❑ hepatitis A, B,or C
- ❑ MRSA

Psychiatric
- ❑ depression
- ❑ anxiety
- ❑ panic attacks
- ❑ _____

Women only **Pregnant** ❑ Yes ❑ No **Breast Feeding** ❑ Yes ❑ No **Date of last menstrual period:** _____

Height: _____ **Weight:** _____

To the best of my knowledge the information provided is accurate.

Patient/Responsible party signature: _____ **Date:** _____