Central Texas
Sports Medicine & Orthopaedics
A part of Brazos Valley Physicians Alliance

Last Name: _____ Primary Care Physician: _____

First Name: _____Preferred Name:_____ Referring Provider: _____

Address: _____ APT/Unit:_____ DOB: ____/_____/_____ Age: ___

City: _____ Sex (circle): *Male / Female* Marital Status (circle): *Single / Married / Other*

State: _____ Zip: _____ SSN: _____ - _____ - _____ Employer: _____

Employment Status (circle): *Full time / Part time / Retired / Military / Other* Student Status (circle): *Full time / Part time*

Home Phone: _____ Cell Phone: _____ Work Phone: _____

*Your phone number is consent to receive appointment reminders via automated voicemail. To refuse, please write "No voicemail reminders" at the top of this form.*

Email Address: _____

**Billing Statement Recipient:**

Relationship: _____DOB: ____/____/_____

Last Name:_____ First Name: _____

Address:_____ APT/Unit:_____

City: _____State: _____ Zip: _____

Primary Phone: _____

**HIPAA Approved Emergency Contact:**

Relationship: _____

Last Name:_____

First Name: _____

Primary Phone:_____

**Is this visit due to a school / sports-related injury?** (circle) **Yes No** If **Yes**, date of injury: ___/___/_____

**Is this visit due to a work-related injury?** (circle) **Yes No**

## Insurance

**Primary Insurance Carrier:** _____ Coverage Dates: ___/___/_____ to ___/___/_____

Subscriber #_____ Group #_____

Policy Holder's Name:_____ DOB:___/___/_____ Your Relationship:_____

Policy Holder's Address: _____ APT/Unit:_____ City: _____State: _____Zip: _____

**Secondary Insurance Carrier:**_____ Coverage Dates: ___/___/_____ to ___/___/_____

Subscriber #_____ Group #_____

Policy Holder's Name:_____ DOB:___/___/_____ Your Relationship:_____

Policy Holder's Address: _____ APT/Unit:_____ City: _____State: _____Zip: _____

Do you have any **Advance Directives**? (circle) **Yes / No**

If **Yes** please circle:

DNR (Do Not Resuscitate) LW (Living Will)

DPA (Durable Power of Attorney) DTP (Directive to Physicians) MPA (Medical Power of Attorney)

## Assignment of Benefits

I hereby authorize Central Texas Sports Medicine & Orthopaedics to furnish information to an insurance carrier concerning me and/or my dependent's illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account and/or my dependents for any professional services rendered. I understand that I am responsible for any amount not covered by insurance. I certify that the information I have provided to Central Texas Sports Medicine & Orthopaedics is true and correct to the best of my knowledge and I will notify Central Texas Sports Medicine & Orthopaedics of any changes. A copy of this authorization shall be valid as the original. Your receipt will provide all the necessary information for you to file with your insurance company if our office is not contracted with or filing to your insurance carrier.

Patient/Legal Guardian Signature: _____ Date: _____

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## Patient Privacy Notice (HIPAA Policy)

This Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. Protected health information includes any information maintained by Central Texas Sports Medicine and Orthopaedics that could identify you and your health condition.

You have the right to review our notice before signing this consent. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. Individuals who have your permission to access your protected health information are listed below:

| Name | Relationship |
|---|---|
| Name | Relationship |
| Name | Relationship |

By signing this form, you consent to our use and disclosure of your protected health information for treatment, payment, and healthcare operation. You have the right to revoke this consent, in writing, except where we have already made disclosure in reliance on your prior consent.

| Patient/Legal Guardian *Signature* | Patient/Legal Guardian Name *Printed* |
|---|---|

## Authorization to Treat a Minor

***If the patient is under 18 years of age, his/her parent or guardian must read and sign below:***

*I hereby give permission to CENTRAL TEXAS SPORTS MEDICINE & ORTHOPAEDICS and its staff to provide my daughter/son with evaluation (including x-rays) and treatment for his/her injuries.*

| **Parent/Legal Guardian Name *Signature*** | **Patient/Legal Guardian Name *Printed*** |
|---|---|

## External Medication Consent Form

Patient medication history is a list of prescription medications that our practices providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important; as it helps healthcare providers treat your symptoms and/or illness properly while avoiding potentially dangerous drug interactions. Please discuss your medication list with your provider to ensure all medications are properly documented. Over the counter drugs and supplements may not be included in the external medication history. I give permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

| Patient/Legal Guardian *Signature* | Date |
|---|---|

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Last Name: _____ Appointment Date: _____

First Name: _____ Date of Birth: _____

Reason for appointment: _____

Pharmacy Name: _____ Address: _____

City: _____ State: _____ Zip: _____

**Current Medications:** *Please list all current medications.*

| Medication | Dosage | Frequency (Daily, 2x Daily, etc.) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Medication Allergies:** *Please list all medications you are allergic to.*

| Medication | Reaction (Hives, Anaphylaxis, Rash, Stomach Upset, Dizziness) |
|---|---|
| | |
| | |
| | |
| | |

**Past Medical History:** *Please circle all that apply.*

| | | | |
|---|---|---|---|
| *Hypertension* | *HIV/AIDS* | *Headaches* | *Hepatitis A* |
| *Diabetes* | *Lung Disease* | *Eye Disorder* | *Hepatitis B* |
| *Heart Disease* | *Sleep Apnea* | *Glaucoma* | *Hepatitis C* |
| *Pacemaker* | *Stroke* | *Depression* | *Liver Disease* |
| *Arthritis* | *Seizures* | *Anxiety* | **Other:** |
| *Thyroid Disorder* | *Concussions* | *GERD* | **Other:** |
| *Bleeding Disorder* | *Migraines* | *Stomach Problems* | **Other:** |

Have you ever had any problems with anesthesia (put to sleep/waking from anesthesia)? Yes / No
If yes, please describe what sort of problems. _____

**Surgeries:** *Please list all surgeries you have undergone.*

| Date (MM/YY) | Surgery |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

Have you been hospitalized for a non-surgical problem before? Yes / No

If yes, list hospitalizations, the reason for admission and the date in the table below

**Hospitalizations:** *Please list all hospitalizations in which you have not undergone surgery.*

| Date(MM/YY) | Reason for Hospitalization |
|---|---|
| | |
| | |
| | |
| | |

**Family History:** *Please check all that apply. For mental illness and cancer, please specify in the indicated box marked with **.*

| | Diabetes | Hypertension | Heart Disease | Stroke | Mental Illness** | Cancer** | Arthritis | Unknown |
|---|---|---|---|---|---|---|---|---|
| Father | □ | □ | □ | □ | □ | □ | □ | □ |
| Mother | □ | □ | □ | □ | □ | □ | □ | □ |
| Siblings | □ | □ | □ | □ | □ | □ | □ | □ |
| Paternal Grandfather | □ | □ | □ | □ | □ | □ | □ | □ |
| Paternal Grandmother | □ | □ | □ | □ | □ | □ | □ | □ |
| Maternal Grandfather | □ | □ | □ | □ | □ | □ | □ | □ |
| Maternal Grandmother | □ | □ | □ | □ | □ | □ | □ | □ |
| Children | □ | □ | □ | □ | □ | □ | □ | □ |

** Specific Mental Illness or Cancer:_____

## Social History Questionnaire

Name:

*Please check the answer that most accurately describes your behaviors for each question. The answers to these questions provide valuable information to your doctor regarding factors that affect your health status.*

**Alcohol Assessment**

1. Did you have a drink containing alcohol in the past year?
   ❑Yes ❑No
2. If yes, how often do you have a drink containing alcohol?
   ❑Never ❑Monthly or less ❑2-4 times a month ❑2-3 times a week ❑4 or more times a week
3. If yes, how many drinks did you have on a typical day when you were drinking in the past year?
   ❑1 or 2 ❑3 or 4 ❑5 or 6 ❑7 or 8 ❑9 or more
4. How often do you have six or more drinks on one occasion?
   ❑Never ❑Less than monthly ❑Monthly ❑Weekly ❑Daily or almost daily

**Smoking/Tobacco/Drug Assessment**

1. Have you ever used tobacco?
   ❑Yes ❑No
2. Are you a former smoker?
   ❑Yes ❑No

If former smoker, when did you start smoking? _____(year)
When did you stop smoking?_____(year)

3. What type of Tobacco do you/did you use?

❑Chain smoker

❑Chews loose leaf tobacco

❑Chews tobacco

❑Heavy cigarette smoker (20-39 cigs/day)

❑Moderate cigarette smoker (10-19 cigs/day)

❑Rolls own cigarettes

❑Trivial cigarette smoker (less than one cigarette/day)

❑Chews fine cut tobacco

❑Chews plug tobacco

❑Chews twist tobacco

❑Light cigarette smoker (1-9 cigs/day)

❑Pipe smoker

❑Snuff User

❑User of moist powdered tobacco

4. Do you use recreation drugs?
   ❑Yes ❑No

**Review of Systems**

Name: _____

Height ____’_____’’ Weight _____ Have you had a bone density scan in the past two years? Y / N
*Feet* *Inches* *Pounds* If yes, where? _____ When? _____
Have you had X-ray/MRI for this injury? Y / N Have you fallen in the last year? Y / N
If yes, where? _____When? _____ If yes, did you sustain any injuries from your fall? Y / N

*Please check all that apply.*

**General Health Problems:**
❑Fever
❑Chest pain
❑Sleeping problems
❑Headaches
❑Unintentional weight loss
❑Unintentional weight gain

**Eye Problems:**
❑Double vision
❑Itchy eyes

**Ear Problems:**
❑Ear pain
❑Ear drainage

**Nose/Sinus Problems:**
❑Chronic congestion
❑Hay fever
❑Post nasal drainage

**Mouth/Throat Problems:**
❑Change in voice
❑Snoring
❑Sore throat
❑Ulcers

**Heart/Blood Vessel Problems:**
❑Blacking out or fainting
❑Bluish discoloration of lips/fingernails
❑Chest pain
❑Irregular heartbeat
❑Leg cramps
❑Swelling of ankles

**Lung/Respiratory Problems:**
❑Frequent non-productive cough
❑Frequent productive cough
❑Shortness of Breath
❑Wheezing

**Muscle/Bone Problems:**
❑Muscle pain
❑Back pain
❑Cramping
❑Popping joints
❑Stiffness in joints
❑Bruising
❑R / L / Bilateral Shoulder pain
❑R / L / Bilateral Knee pain
❑R / L / Bilateral Ankle pain
❑R / L / Bilateral Hand/wrist pain
❑R / L / Bilateral Hip pain
❑R / L / Bilateral Elbow pain
❑Other: _____

**Stomach (Gastrointestinal) Problems:**
❑Abdominal pain
❑Diarrhea
❑Heartburn
❑Nausea,
❑Vomiting

**Brain/Nervous System Problems:**
❑Numbness
❑Seizures
❑Severe face pain
❑Weakness

**Glands/Hormones Problems:**
❑Feel cold all the time
❑Feel hot when others do not
❑Increased appetite
❑Increased fatigue
❑Neck has enlarged
❑Unwanted weight change

**Blood/Lymph Nodes Problems:**
❑ Bleeds excessively after injury
❑Bruises easily

**Allergy Problems:**
❑Food intolerances
❑Hives
❑Frequent sneezing
❑Severe reaction to insect bite