Central Texas
Sports Medicine & Orthopaedics, P.A.

Patient Information Sheet

PLEASE PRINT LEGIBLY AND COMPLETE ALL INFORMATION Today's Date: _____

Patient's Name: _____ Nickname (if any): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (☑ **please indicate which is your primary number**): ☐Home:(___)_____ ☐Cell:(___)_____

By providing your phone number, you consent to receive appointment reminders by our automated voicemail system. If not, please write "No Voicemail Reminders" at the top of this form.

Social Security No.: _____ Birthdate: _____ Age: _____ Gender: Male / Female

Race: ☐ American Indian ☐ African-American ☐ Asian ☐ White ☐ Hispanic ☐ Native Hawaiian ☐ Other:_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Language Spoken: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Email address: _____

Employer: _____ Occupation: _____ Work Phone: (____)_____

Is this a school/sports-related injury? ***Yes No*** If ***Yes***, date of injury: _____ School _____

Is this a work-related injury? ***Yes No*** **If so, are you filing with Workers Comp?** ***Yes No***

Responsible party for this account (if different from patient): _____ _____
Name Address

_____ _____ _____ (____)_____ (____)_____
City State Zip Home Phone Cell Phone

Who may we thank for referring you to our office? _____

Emergency Contact Person: _____ _____ _____
Name Relationship to you Phone

Primary Insurance Company: _____ Group/Policy Number _____
Policyholder's Name: _____ Policyholder's DOB: _____
Policyholder's Social Security No:_____ ID# on Card: _____
Relationship of the patient to the policyholder: SELF SPOUSE DEPENDENT

Secondary Insurance Company: _____ Group/Policy Number _____
Policyholder's Name: _____ Policyholder's DOB: _____
Policyholder's Social Security No:_____ ID# on Card: _____
Relationship of the patient to the policyholder: SELF SPOUSE DEPENDENT

ASSIGNMENT OF BENEFITS

I hereby authorize Central Texas Sports Medicine & Orthopaedics, P.A. 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, P.A. is true and correct to the best of my knowledge and I will notify Central Texas Sports Medicine & Orthopaedics, P.A. 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's Signature (or signature of parent/guardian for minor patients) Date

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Patient Privacy Notice (HIPPA Form) And Authorization to Treat Minor

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, P.A. 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.

Signature of Patient (or Parent/Guardian°)	Date
Patient Name - Printed	Parent/Guardian Name - Printed

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

AUTHORIZATION TO TREAT MINOR

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.

Signature of parent or legal guardian	**Date**

P Drive:Forms/HIPAA Release and Minor Authorization Form

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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 make sure to discuss your medication list with your provider to ensure all mediations 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 /Guardian Signature Date

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Full Name _____ **Date of Birth** _____ **Appointment Date** _____

Pharmacy Preference (include location) _____

Name of Primary Care (Family) Physician _____ **Referred by** _____

What is the reason you are seeing the doctor today? _____

Height _____ **Weight** _____

Have you fallen in the last year? ☐ **Yes** ☐ **No** **If yes, did you sustain any injuries from your fall?** ☐ **Yes** ☐ **No**

CURRENT MEDICATIONS:

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications)
☐ **Yes** ☐ **No** **If yes, please list below and *include dosages*.**

Medication	Dose	How often taken

MEDICATION ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ **Yes** ☐ **No** **If yes, please list below.**

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	

ARE YOUR IMMUNIZATIONS CURRENT? ☐ **YES** ☐ **NO**

SURGERIES:

Date	Surgery

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

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:

Date	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*
Father	□	□	□	□	□	□	□
Mother	□	□	□	□	□	□	□
Siblings	□	□	□	□	□	□	□
Paternal Grandfather	□	□	□	□	□	□	□
Paternal Grandmother	□	□	□	□	□	□	□
Maternal Grandfather	□	□	□	□	□	□	□
Maternal Grandmother	□	□	□	□	□	□	□
Children	□	□	□	□	□	□	□

***** Please specify:***_____

Check here if family history is unknown: ☐

REVIEW OF SYMPTOMS

Please check all that apply

General Health Problems: ☐ No ☐ Yes

- ☐ Fever
- ☐ Sleeping problems
- ☐ Headaches
- ☐ Unintentional weight loss
- ☐ Unintentional weight gain

Eye Problems: ☐ No ☐ Yes

- ☐ Double vision
- ☐ Itchy eyes

Ear Problems: ☐ No ☐ Yes

- ☐ Ear pain
- ☐ Ear drainage
- ☐ Hearing loss
- ☐ Dizziness
- ☐ Ringing

Nose & Sinus Problems: ☐ No ☐ Yes

- ☐ Chronic congestion
- ☐ Hay fever
- ☐ Post nasal drainage

Mouth & Throat Problems: ☐ No ☐ Yes

- ☐ Change in voice
- ☐ Snoring
- ☐ Sore throat
- ☐ Ulcers

Heart or Blood Vessel Problems: ☐ No ☐ Yes

- ☐ Blacking out or fainting
- ☐ Bluish discoloration of lips or fingernails
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Leg cramps
- ☐ Swelling of ankles

Lung or Respiratory Problems: ☐ No ☐ Yes

- ☐ Frequent non-productive cough
- ☐ Frequent productive cough
- ☐ Shortness of breath
- ☐ Wheezing

Muscle or Bone Problems: ☐ No ☐ Yes
circle side of pain when prompted

- ☐ 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): ☐No ☐ Yes

- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea,
- ☐ Vomiting

Brain or Nervous System Problems: ☐ No ☐ Yes

- ☐ Numbness
- ☐ Seizures
- ☐ Severe face pain
- ☐ Weakness

Problems with Glands, Hormones: ☐No ☐ Yes

- ☐ Feel cold all the time
- ☐ Feel hot when others do not
- ☐ Increased appetite
- ☐ Increased fatigue
- ☐ Neck has enlarged
- ☐ Unwanted weight change

Blood or Lymph nodes Problems: ☐ No ☐ Yes

- ☐ Bleeds excessively after injury
- ☐ Bruises easily

Problems with Allergies: ☐ No ☐ Yes

- ☐ Food intolerances
- ☐ Hives
- ☐ Frequent sneezing
- ☐ Severe reaction to insect bite

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Social History Questionnaire

Patient Name _____ Date of Visit _____

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

   If yes, what type? _____
   If yes, how frequently? _____
2. **Are you a former smoker?**
   - ☐ Yes
   - ☐ No

   If yes, when did you quit?
   _____ years/months ago
3. **Are you exposed to second hand smoke?**
   - ☐ Yes
   - ☐ No
4. **Do you use recreation drugs?**
   - ☐ Yes
   - ☐ No