Central Texas
Sports Medicine & Orthopaedics, P.A.

Patient Information

*Please print legibly and **complete all information**. If a prompt does not apply, **please draw a line through the space provided**.*

Last Name: _____ Primary Care Physician: _____

First Name: _____ Referring Provider: _____

Billing Address: _____ Date of Birth: _____ 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: _____

Responsible Party *(Statements will be addressed to Responsible Party)*

Relationship: _____

Last Name: _____

First Name: _____

Home Phone: _____

Emergency Contact *(HIPAA approved contact on page 2)*

Relationship: _____

Last Name: _____

First Name: _____

Home Phone: _____

Primary Insurance (circle): *Personal / Employer plan / Workers' Compensation / School*

Insurance Carrier: _____ Coverage Dates: _____

Subscriber Number: _____ Group Number: _____

Insured's Name: _____ DOB: _____ Specialist Co-Pay: _____

Insured's Address: _____ City: _____ State: _____ Zip: _____

Patient Relationship to Insured (circle): *Self / Spouse / Natural child / Step Child / Foster Child / Other:* _____

Secondary Insurance (circle): *Personal / Employer plan / Workers' Compensation / School*

Insurance Carrier: _____ Coverage Dates: _____

Subscriber Number: _____ Group Number: _____

Insured's Name: _____ DOB: _____ Specialist Co-Pay: _____

Insured's Address: _____ City: _____ State: _____ Zip: _____

Patient Relationship to Insured (circle): *Self / Spouse / Natural child / Step Child / Foster Child / Other:* _____

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/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, 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.

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 or Legal Guardian *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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Medical History

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/awaking 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

Please check the answer the 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

   If yes, what type? _____ Frequency (daily, weekly, monthly, etc.): _____

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

Review of Systems

Height ____’_____’’ Weight _____
Feet *Inches* *Pounds*

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

Please check all that apply.

General Health Problems:
- ☐ Fever
- ☐ Sleeping problems
- ☐ Headaches
- ☐ Unintentional weight loss
- ☐ Unintentional weight gain

Eye Problems:
- ☐ Double vision
- ☐ Itchy eyes

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

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