

**Chief Complaint Form:**

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

Patient Name: \_\_\_\_\_

First

MI

Last

Preferred Name

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Send Note?

Referring Physician: \_\_\_\_\_ Town: \_\_\_\_\_ Y N

Primary Care Physician: \_\_\_\_\_ Town: \_\_\_\_\_ Y N

Body part being seen for: \_\_\_\_\_

Side of Body: (circle)      Right      Left      Both

Date Symptoms Began: \_\_\_\_\_

Was there an injury? (circle)      Yes      No      Workers Comp? (circle)      Yes      No

If so, how did it happen? \_\_\_\_\_

Current Symptoms: \_\_\_\_\_

If there is pain, where is it located? \_\_\_\_\_

Are your symptoms? (circle)      Improving      Worsening      Stable

Are your symptoms? (circle)      Mild      Mild/Mod.      Moderate      Mod./Severe      Severe

Do you use an assistive device? (circle)      Cane      Walker      Scooter      Wheelchair

What activities or body positions make you symptoms worse? (ex. Walking, running, reaching overhead)

Have you had prior treatment? (ex. Injections, medications, physical therapy, surgery?)

Are you taking pain medications?

(Examples: NSAIDs (Ibuprofen, Advil, Meloxicam, Celebrex), narcotics (oxycodone, hydrocodone, Norco, Percocet, Oxycontin, Tramadol), etc.)

List drug name, dosage, and prescribing physician

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Medical History:

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Check if you have had any of these **medical problems** in the PAST:

MAJOR ILLNESS	YES	NO	MAJOR ILLNESS	YES	NO
Anemia			Liver Disease		
Arthritis: Type _____			Low back pain/Spine problems		
Heart Arrhythmia			Kidney Disease		
Asthma			MRSA (resistant staph)		
Bleeding Problems			Neuropathy		
Cancer: Type _____			Osteoporosis/Osteopenia		
Chest Pain/ Angina			Paralysis		
Deep Vein Thrombosis			Peripheral Vascular Disease		
Diabetes			Psychiatric Illness: Type _____		
Gall Bladder Disease			Pulmonary Embolism		
Gastric Ulcers			Reflux		
Glaucoma			Skin Ulcer/ Breakdown		
Gout			Steroid Use		
Heart Attack			Stroke		
Heart Failure			Thyroid Disease		
Heart Murmur			Tuberculosis- TB		
Hepatitis B			Urinary Infections		
Hepatitis C			Valve Disorders (heart)		
High Blood Pressure			Wound Healing Problems		
HIV/AIDS			OTHER: _____		
Immune Deficiency					

Please list any **operations/surgeries** you have had:

SURGERY/ REASON	YEAR	SURGERY/REASON	YEAR
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Please list any **Medication** that you are currently taking:

MEDICATION	DOSE	DOCTOR	MEDICATION	DOSE	DOCTOR
1)			5)		
2)			6)		
3)			7)		
4)			8)		
5)			10)		

Do you have any **allergies** to medications/substances?

Yes

No

Pharmacy name and location:

**Family Medical History-** Please list major illnesses that affect immediate family:

MEDICAL ILLNESS	RELATION	MEDICAL ILLNESS	RELATION
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Have any family members had a knee or hip replacement? (circle) YES NO

RELATION	Surgery for Arthritis (Hip or knee replacement)
1)	
2)	
3)	
4)	

**Social History:**

Alcohol use: Yes No Drinks per week: \_\_\_\_\_  
Cigarette use: Yes No Packs per day: \_\_\_\_\_ Years \_\_\_\_\_  
Smokeless tobacco use: Yes No Years: \_\_\_\_\_  
Other Drugs: Yes No Type: \_\_\_\_\_

**Review of Symptoms-** Please mark any of the symptoms that apply to you TODAY:

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Tarry Stools			Frequent Urination		
Vomiting			Urgent Urination		
Abdominal Pain			Painful Urination		
Chest Pain			Muscular Weakness		
Irregular Heart Beat			Numbness or Tingling		
Rapid Heart Beat			Joint Pain or Swelling		
Swelling of Legs			Muscle Pain or Swelling		
Cough			Frequent/ Easy Bruising		
Shortness of Breath			Cuts that don't stop bleeding		
Rash			Anxiety		
Wound Healing Problem			Depression		
Fever/Chills			<u>Nausea/vomiting</u>		
<u>Unintended weight loss</u>			<u>Diarrhea</u>		
<u>Seizures</u>					
<u>Fainting/falls</u>			<u>Other:</u>		

Deleted: Other:

*Agreement of Accuracy:* The information provided in this history form is true and complete to the best of my knowledge.

*Notice of Privacy Practices:* I am aware that Andrews Orthopaedic and Sports Medicine Center has a "Notice of Privacy Practices" in accordance with Baptist Health Care's privacy policies. I understand that a copy is available to me and I agree with these policies.

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

**Patient Demographics:**

Patient Name: \_\_\_\_\_

First                          MI                          Last                          Preferred Name

SSN#: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex:    Male    Female

Address: \_\_\_\_\_  
Street Address                          City                          State                          Zip Code

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Marital Status:    Married        Single    Divorced    Widowed  
 Race:    African American        Asian        White        Hispanic        Other  
 Ethnicity:    Hispanic or Latino    Non-Hispanic or Latino

Email Address: \_\_\_\_\_

How were you referred to our practice? (Circle)

Friend/Relative: \_\_\_\_\_ Physician        Newspaper        Radio        Healthsource

**Guardian Information: (If Patient is a Minor)**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

SSN#: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex:    Male    Female

Address: \_\_\_\_\_  
Street Address                          City                          State                          Zip Code

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

**Payment Information:**

Form of Payment:    Health Insurance    Auto Insurance    Worker's Compensation    Self Pay

**Primary Insurance**

Primary Insurance Company: \_\_\_\_\_ Insured's Name \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

**Secondary Insurance**

Secondary Insurance Company: \_\_\_\_\_ Insured's Name \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

**Self-Pay Agreement**

I agree to pay for medical services rendered at Andrews Orthopaedic and Sports Medicine facilities. I understand that there are payment plans available at my request.

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

*Release of Information:* I authorize Andrews Orthopedic and Sports Medicine Center to release medical information requested by my health insurance, Medicare, or third- party payers in order to assist in the payment of claims.

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

**Disclosure to Release Information to Families/ Emergency Contacts and Physicians**

I authorize Baptist Physicians Group to disclose my health care information and to discuss my health care needs with those that I designate. I further authorize the release of my billing information to the following individuals and give them the ability to pick up prescriptions and/or forms. etc., on my behalf. A photo ID is required for any pick up. These individuals will be considered my emergency contacts. Without authorization, no information may be shared.

Important Note: If you may want or need any healthcare information or scheduling information released to any individuals they need to be specifically listed below. This includes individuals such as: a parent or child of a patient over 18 years of age, your primary care physician, your insurance policy holder, and/or sport coaches etc.

I authorize Baptist Physicians Group and his staff to disclose my personal health information to the following people:

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Consent to Treatment**

I hereby grant authorization and consent for medical treatment and /or procedures for myself or for the patient for whom I am the parent or legally authorized guardian, and I understand that no guarantees or assurance has been made as to the results for which may be obtained.

\_\_\_\_\_  
Patient or Guardian Initials

**Photo Documentation**

I hereby grant authorization for the office staff to make a copy of my photo identification to be included in my confidential record as well as take a digital picture as additional protection against the theft of my medical identity. I further grant authorization for the office staff to take photo identification of any injury or procedure that they feel is medical y necessary to include in my confidential medical record.

\_\_\_\_\_  
Patient or Guardian Initials

**Notice of Privacy Practices**

I have reviewed a copy of the Baptist Health Care "Notice of Privacy Practices" and understand that a copy is available upon request, I agree with these privacy policies.

\_\_\_\_\_  
Patient or Guardian Initials

**Insurance Assignment and Financial Responsibility**

I hereby authorize Baptist Physicians Group to release any medical information required during the course of examination and treatment to my insurance company and/or third-party payers in order to assist in the payment of claims. I permit payment to Baptist Physicians Group form my insurance for services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to co-insurance, co-payment, deductible, and non-coverage services. I understand that I am responsible for all charges incurred regardless of the insurance status. I agree to pay my bill in full for services rendered by Baptist Physicians Group.

\_\_\_\_\_  
Patient or Guardian Initials

Print Name of Patient or Guardian: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_