ANDREWS INSTITUTE
ORTHOPAEDICS & SPORTS MEDICINE
An Affiliate of Baptist Health Care

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

Coach/ Trainer/ Team Doctor: _____ School: _____ 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

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

_____

_____

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

_____

_____

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			Immune Deficiency		
Arthritis: Type _____			Liver Disease		
Heart Arrhythmia			Kidney Disease		
Asthma			MRSA (resistant staph)		
Bleeding Problems			Neuropathy		
Cancer: Type _____			Paralysis		
Chest Pain/ Angina			Peripheral Vascular Disease		
Deep Vein Thrombosis			Psychiatric Illness: Type _____		
Diabetes			Pulmonary Embolism		
Gall Bladder Disease			Reflux		
Gastric Ulcers			Skin Ulcer/ Breakdown		
Glaucoma			Steroid Use		
Gout			Stroke		
Heart Attack			Thyroid Disease		
Heart Failure			Tuberculosis- TB		
Heart Murmur			Urinary Infections		
Hepatitis B			Valve Disorders (heart)		
Hepatitis C			Wound Healing Problems		
High Blood Pressure			OTHER: _____		
HIV/AIDS					

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)	

Social History:

Alcohol use: Yes No Drinks per week: _____

Cigarette use: Yes No Packs per day: _____ Years_____

Smokeless tobacco use: Yes No Years: _____

Illicit 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			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: _____