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ORTHOPAEDICS & SPORTS MEDICINE
An Affiliate of Baptist Health Care

Patient Demographics:

Patient Name: _____ _____
First MI Last Preferred Name

SS#: _____ Birth date: _____ Sex: Male Female

Address: _____ _____ ____ _____
Street Address City State Zip

Home #: _____ Cell #: _____ Work#:_____

Marital Status: Married Single Divorced Widowed

Race: African American Asian/Pacific Islander Caucasian Hispanic
Other:_____

Email address:_____

Payment Information:
Form of Payment: Health Insurance Auto Insurance Workers Comp Self Pay

Primary Insurance
Primary Company:_____ Insured's name:_____
Policy #:_____ Group #:_____ Insured's Date of Birth:_____

Secondary Insurance
Secondary Company:_____ Insured's name:_____
Policy #:_____ Insured's Date of Birth:_____

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

x _____ Date: _____

Release of Information: I authorize Andrews Orthopaedic 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: _____

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Patient Medical History:

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

MAJOR ILLNESS	YES	NO	**MAJOR ILLNESS**	YES	NO
Blood Clots			Pneumonia		
Pulmonary Embolism			Tuberculosis – TB		
Anemia			Steroid Use		
Bleeding Problems			Wound Healing Problems		
Asthma			Urinary Infections		
High Blood Pressure			Kidney Disease		
Heart Arrhythmia			Liver Disease		
Heart Attack			Neuropathy		
Heart Failure			Paralysis		
Heart Murmur			Peripheral Vascular Disease		
Valve Disorders (heart)			Gastric Ulcers		
Stroke			Reflux		
Cancer: Type _____			Sleep Apnea		
Diabetes			Gout		
MRSA (resistant staph)			Thyroid Disease		
HIV/AIDS			Psychiatric Illness: Type_____		
Immune Deficiency			Skin Ulcer/Breakdown		
Hepatitis B			OTHER:		
Hepatitis C					

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

SURGERY	YEAR	**SURGEON**
1)		
2)		
3)		
4)		
5)		
6)		
7)		

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Please list any **Medications** that you are currently taking:
You may attach list if you prefer:

MEDICATION	**DOSE**	**How do you take? (daily, twice daily, as needed, etc)**
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

Do you have any **allergies** to medications/substances? Yes No

MEDICATION/SUBSTANCE	**Reaction**
1)	
2)	
3)	
4)	

Pharmacy name and location:_____

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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:	Yes	No	
Alcohol use			Drinks per week:
Cigarette use			Packs per week: ½ ¾ 1 2 Years:
Chewing tobacco/snuff			Years:
Illicit drugs			Type:

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

SYMPTOM	YES	NO
Fever/Chills		
Fatigue		
Weight loss		
Chest Pain		
Irregular Heart Beat		
Shortness of Breath		
Cough		

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 privacy policies.

x _____ Date: _____

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Chief Complaint Form

Date:

Patient Name: _____ Age:___

Height: Weight:

Primary Care Physician: _____ Town: _____

1.) Where is your pain? Hip Knee

2.) Side of Body: Right Left Both (Which is worse: R L)

3.) Date Symptoms Began: _____

4.) Are you using? Cane Crutches Walker

5.) Was there an injury? Yes No
If so, how did it happen?
_____

6.) Current Symptoms: Dull Sharp Ache Stabbing Throbbing
Other: _____

7.) Are your symptoms? Improving Worsening Stable

8.) Current Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

9.) What activities or body positions make your symptoms worse?

Walking Running Stairs Getting up from seat Kneeling

Standing Lying on that side Sports:_____

10.) Prior treatments?

Injections	How many	Last one	Type
R / L / Both			Cortisone/Synvisc

Medications: Tylenol, Aleve, Ibuprofen Other pain meds :_____
Physical Therapy: ___ Bracing: _____
Modalities: Ice Heat Ultrasound Massage Acupuncture

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Disclosure to Release Information to Families/Emergency Contacts & Physicians

I authorize Dr. G. Daxton Steele 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 health care 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 any sport coaches, etc.

I authorize Dr. G. Daxton Steele 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 guarantee or assurance has been made as to the results for which may be obtained.

_____
Patient or Guardian's 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 medically necessary to include in my confidential medical record.

_____
Patient or Guardian's 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 to me upon request. I agree with these privacy policies.

_____
Patient or Guardian's Initials

Insurance Assignment and Financial Responsibility

I hereby authorize the office of Dr. G. Daxton Steele 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 Dr. G. Daxton Steele from 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-covered 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 Dr. G. Daxton Steele.

_____
Patient or Guardian's Initials

Patient or Guardian Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____