SPORTS MED Wheaton Orthopaedics

CONSENT FORM

Patient Name: _____ **DOB:** _____

1. Consent to Diagnose and Treat. I hereby consent to diagnostic and medical treatment by SportsMed-Wheaton Orthopaedics' physicians and/or their designated staff. I understand that any procedure (such as injections, I&D, parings, etc.) has risks, which include but are not limited to infection, bleeding, pain and/or swelling.

2. Electronic Prescriptions. I agree that SportsMed-Wheaton Orthopaedics may request and use my prescription medication history from other healthcare providers or third party pharmacy payers for treatment purposes.

3. Assignment of Benefits and Agreement to Pay. I understand I am financially responsible for any co-payments, deductibles, coinsurance, medical supplies and equipment, or any other amounts not covered by my insurance. I authorize direct payment to SportsMed-Wheaton Orthopaedics for all covered services, equipment and supplies. I understand it is my responsibility to obtain referrals from my primary care physician if required by my plan. It is my responsibility to contact my insurance company with any questions regarding eligibility and coverage. *Payment is due within 30 days of receipt of statement*. In the event legal action must be taken to collect any balance due, I will be responsible for the cost of collection and reasonable legal fees related to my account.

4. Consent for Release of Information for Payment. I hereby authorize SportsMed-Wheaton Orthopaedics to release to my insurance companies, government agencies, employer or third party payers and their agents, information concerning my medical care and treatment, supplies or other information necessary to determine eligibility and benefits and to obtain payment for healthcare services rendered to me. I also consent for release of information needed to complete FMLA and Disability Forms.

5. Notice of Privacy Practices. I hereby acknowledge receipt of SportsMed-Wheaton Orthopaedics' Notice of Privacy Practices. The Notice provides detailed information about how the practice may use and disclose my confidential health information. I understand the practice has the right to change its privacy practices described in the Notice and that a copy of any Revised Notice will be made available in the office or at www.sportsmedltd.com.

6. Financial Policy. I have received and agree with the SportsMed-Wheaton Orthopaedics Financial Policy.

7. Patient Communicator. I agree SportsMed-Wheaton Orthopaedics may use my e-mail address to activate the Patient Portal. This allows me to view my clinical information and communicate with my doctor electronically or _____ I decline the Patient Portal.
   X to decline

   My email address is: _____

8. I give permission for SportsMed-Wheaton Orthopaedics to leave messages at the phone numbers I have provided.

9. My ***preferred*** phone number for ***medical messages*** is (circle ***one***): **Home Phone** **Cell Phone** **Work Phone**

10. I give permission for SportsMed-Wheaton Orthopaedics to leave messages or discuss information with the people listed below:

Name_____ Phone _____ Relationship _____

Name_____ Phone _____ Relationship _____

X _____ _____
Signature of patient or authorized representative or Parent or legal guardian if patient is a minor — Date

_____ _____
Name of parent or authorized representative (please print) — Relationship to patient

Only if Patient is a Minor (< *18 years old*) or Dependent Adult complete the following section.
List all parties you are giving permission for SportsMed-Wheaton Orthopaedics to discuss information or leave messages with regarding this patient**:**

Mother's Name: Mother's Telephone Number: Home Work Cell ( )	Father's Name: Father's Telephone Number: Home Work Cell ( )
Step-Mother's Name: Step-Mother's Telephone Number: Home Work Cell ( )	Step-Father's Name: Step-Father's Telephone Number: Home Work Cell ( )
Other's Name: Relationship to Patient: Other's Telephone Number: Home Work Cell ( )	Other's Name: Relationship to Patient: Other's Telephone Number: Home Work Cell ( )

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INTAKE FORM

Patient Name: _____ DOB: _____

Phone number verification (please list):

Home _____ Cell _____ Work _____

Race (circle one, or more, if applicable):

American Indian or Alaskan Native | Asian | Black or African American

Native Hawaiian or other Pacific Islander | White | Decline

Ethnicity (circle one): Hispanic Origin | Non-Hispanic Origin | Decline

Preferred Language: _____ Decline

Smoking Status: (select one)

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker

☐ Heavy tobacco smoker ☐ Light tobacco smoker ☐ Smoker, current status unknown ☐ Unknown if ever smoked

If a current smoker, what year did you start? _____ ***Number of packs per day?*** _____

If a former smoker, what year did you start? _____ ***What year did you stop?*** _____

Preferred Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone Number: _____

_____ _____

Patient Signature Date

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Health History

Name: _____ DOB: _____Age:_____ ☐ Male ☐ Female

Height: _____ Weight: _____ ☐ Right Handed ☐ Left Handed

Primary Care Physician: _____ Phone: _____

Address: _____

Your Medical History (Check all that apply)

☐ Alcoholism	☐ Depression	☐ Heart Attack/Disease	☐ Liver Disease	☐ Sleep Apnea
☐ Asthma	☐ Diabetes Type ____	☐ Hepatitis	☐ Mitral Valve Prolapse	☐ Stomach Ulcers
☐ Bleeding Disorder	☐ Emphysema/COPD	☐ High Blood Pressure	☐ Multiple Sclerosis	☐ Stroke
☐ Blood Clot/DVT	☐ Epilepsy/Seizures	☐ High Cholesterol	☐ Osteoporosis	☐ Thyroid Problems
☐ Cancer Type_____	☐ Esophageal Reflux/GERD	☐ HIV	☐ Pacemaker/Defibrillator	☐ Other (List):
☐ Chemical Dependency	☐ Gout	☐ Kidney Disease	☐ Parkinson's Disease	_____

In the past 12 months

Have you had a fall that resulted in an injury? ☐ NO ☐ YES

Have you had a bone density test (Dexascan)? ☐ NO ☐ YES

Surgeries/Hospitalizations

Year	Surgery/Hospitalization

Year	Surgery/Hospitalization

Have you had any problems with anesthesia? ☐ NO ☐ YES If yes, explain _____

Allergies ☐ No Allergies ☐ Yes (List allergy and type of reaction)

	Reaction		Reaction
☐ Latex	_____	☐ Egg Products	_____
☐ Penicillin	_____	☐ Metal	_____
☐ Sulfa	_____	☐ Other:	_____

Medication History (List all prescription drugs, vitamins, supplements, over the counter meds)

	Medication	Strength	When do you take it?	Reason you take it
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Review of Systems **(Check any symptoms you have had in the past month)**

☐ Fever/Chills	☐ Vision Changes	☐ Headaches	☐ Skin Rash
☐ Nausea/Vomiting	☐ Hearing Changes	☐ Bleeding/Blood Clots	☐ Chest Pain/Palpitations
☐ Abdominal Pain	☐ Dizziness	☐ Shortness of Breath	☐ Other: _____

Social History

Marital Status (circle one): Single Married Widowed Separated Divorced Significant Other

Do you live alone? ☐ NO ☐ YES

Do you use Alcohol? ☐ NO ☐ YES # Drinks/Week: _____

Currently Smoking? ☐ NO ☐ YES

Do you use recreational drugs? ☐ NO ☐ YES

Occupation: _____ Name of work Facility: _____

What exercise, sports or recreational activities do you participate in? _____

Family Medical History (Has any parent, child or sibling had any of the following? If yes, specify who.)

Diabetes	☐ No	☐ Yes	Who: _____
Heart Disease	☐ No	☐ Yes	Who: _____
High Blood Pressure	☐ No	☐ Yes	Who: _____
Rheumatoid Arthritis	☐ No	☐ Yes	Who: _____
Stroke	☐ No	☐ Yes	Who: _____

_____ _____

Signature of patient or authorized representative or Parent or legal guardian if patient is a minor

Date

_____ _____

Print Name of parent or authorized representative

Relationship to patient

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New Problem Form

Name: _____ DOB: _____ Referred By: _____

Body Part: _____ ☐ RT ☐ LT ☐ Both How long have you had problem? _____

If an injury occurred: Date of Injury_____ Where did injury occur? ☐ Home ☐ Work ☐ Other _____

Describe what happened: _____

Off work due to injury? ☐ NO ☐ YES If yes, last day worked: _____ Work Restrictions: _____

Pain: (Check all that apply or describe) _____

Type: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Burning ☐ Aching Is your pain constant? ☐ NO ☐ YES

Severity: ☐ Mild ☐ Moderate ☐ Severe Does your pain radiate? ☐ NO ☐ YES If so, where? _____

Symptoms: (Check all that apply or describe) _____

☐ Instability	☐ Swelling	☐ Numbness/Tingling	☐ Clicking/Grinding
☐ Weakness	☐ Stiffness/Limited Motion	☐ Catching/Locking	☐ Discoloration

Any prior treatment for this problem? ☐ NO ☐ YES If yes, by whom? _____ When? _____

Tests done (check) ☐ X-ray ☐ MRI Other: _____ When/where was test done? _____

Brace, orthotic or assistive device? ☐ NO ☐ YES If yes, what type? _____

Do you use (check)? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Splint ☐ Cast

Activities that aggravate symptoms:

☐ Up from chair/bed	☐ Running/Jumping	☐ Kneeling/Squatting	☐ Walking
☐ Stairs	☐ Repetitive Motion	☐ Stooping/Bending	☐ Overhead movements
☐ Sitting	☐ Lifting/Carrying	☐ Standing	Other _____

Treatments that alleviate symptoms:

☐ Ice	☐ Heat	☐ Rest	Other _____

Medications you have taken for this problem:

Medication	Does it help?		How long have you been on it?
1. _____	☐ No	☐ Yes	_____
2. _____	☐ No	☐ Yes	_____

_____ _____

Signature of patient or authorized representative or Parent or legal guardian if patient is a minor

Date

_____ _____

Print Name of parent or authorized representative

Relationship to patient