

Last: _____ First: _____ M.I. _____

Address: _____ Sex: M / F
Street or PO Box City State Zip Code

Home Phone: _____ Mobile Phone: _____ Date of Birth: _____ Age: _____

Email address: _____

Social Security #: _____ Driver's Lic #: _____ Marital Status: _____

Employer: _____ Occupation: _____ Work Phone #: _____

Spouse Name: _____ Employer: _____ Work Phone #: _____

IF PATIENT IS A MINOR OR RESIDES WITH PARENTS, PLEASE COMPLETE THE FOLLOWING

Father's Name: _____ Employer: _____ Wk Phone #: _____

Mother's Name: _____ Employer: _____ Wk Phone #: _____

INSURANCE INFORMATION – PLEASE PROVIDE CARD SO WE MAY SCAN A COPY

Insurance is filed as a courtesy. Co-payments are expected at the time of services.

Primary Insurance: _____ Secondary Insurance: _____

Is this an accident that occurred during school sports? YES / NO If yes, date _____

Is this a workers' comp accident? YES / NO If yes, date _____

If accident, is there an attorney involved? YES / NO If yes, attorney name _____

In case of emergency, please notify _____ Relation: _____ Phone #: _____

What are you being seen for today? _____ Date of Injury: _____

Who referred you to this practice? _____

ARE YOU COVERED UNDER ANOTHER PERSONS INSURANCE? (EXAMPLE: SPOUSE, PARENT)

Insured's Name (if other than patient): _____ Insured's Date of Birth: _____

Insured's Address: _____ Relation to Patient: _____

Insured's Social Security #: _____

Insured's Home Phone: _____ Mobile Phone: _____ Work Phone: _____

MEDICAL HISTORY

Please mark the box beside any significant medical problem you have.

- Asthma Diabetes Heart Problems Emphysema
- Thyroid Disease Liver Disease Degenerative Arthritis Rheumatoid Arthritis
- Cancer Anemia Yellow Jaundice / Hepatitis High Cholesterol or Triglycerides
- Gout Alcoholism Reaction to Anesthetics Stomach Ulcers, Reflux, Gastritis
- High Blood Pressure Fibromyalgia Fibrositis History of Blood Clots / Phlebitis
- Other _____ Other _____ Other _____ Other _____

Please explain any of the above marked boxes. Include month and year if possible. List the treating physician for each.

Please list all major SURGERIES requiring anesthesia.

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

Please list your MEDICATIONS you are taking AND the dosage. (prescription and over-the-counter)

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

Do you have any ALLERGIES TO MEDICATIONS? YES / NO If yes, please list medication and reaction.

Example: Penicillin (rash)

Date Reviewed: For MD use only
1. _____
2. _____
3. _____
4. _____

- Do you smoke? NO YES Packs per day _____
- Do you drink alcohol? NO YES How often _____
- Illegal (street) drugs? NO YES What? _____

PLEASE LIST YOUR FAMILY PHYSICIAN OR INTERNIST: _____

*Abilene Sports Medicine & Orthopedics
Office Procedures*

Referrals: If your insurance requires a referral from your primary care physician, it is your responsibility to obtain one before you can be seen. If you do not get one, your appointment will be rescheduled. There are no exceptions.

Financial Policy: All co-pays, deductible amounts, and non-covered services for office visits are due at the time of service. If you have any questions please call our office – 325-698-3865.

Insurance: Please bring your current insurance card and picture ID. We will make a photocopy of both your insurance card and picture ID. We will file your insurance for you. All charges will be the patient's responsibility. Any unpaid insurance claims after 60 days will be billed to the patient. Regardless of insurance, payment remains your personal responsibility.

Minors: All minors under the age of 18 must be accompanied by a parent or guardian who is legally allowed to give medical consent.

I have read and understand the procedures of the office of Abilene Sports Medicine & Orthopedics – Dale A. Funk, MD.

Signature of Patient (or Parent/Legal Guardian if under 18 years of age)

Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

Signature of Patient (or Parent/Legal Guardian if under 18 years of age)

Date

Release of Information

I hereby authorize my physician at Abilene Sports Medicine & Orthopedics to release any information obtained in the course of my examination that my insurance company may request. I authorize any holder of medical information about me to release to the insurance, Medicare, or any other health plan or its agents, any information needed to determine these benefits or the benefits payable to related services. Please consider this signature as authorization to release my confidential medical records with written release on the basis of a telephone request. I understand that it is possible for someone to misrepresent themselves by telephone and that my right of privacy may be compromised.

Signature of Patient (or Parent/Legal Guardian if under 18 years of age)

Date

I hereby authorize assignment of my medical and/or surgical benefits to include major medical benefits that I am entitled, private insurance, Medicare, and any other health plans to my physician at Abilene Sports Medicine & Orthopedics. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Signature of Patient (or Parent/Legal Guardian if under 18 years of age)

Date