Office Use Only
Completed by: _____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: M / F

Address: _____
Street or PO Box City State Zip Code

Home Phone: _____ Mobile Phone: _____

Email address: _____

Social Security #:_____ Marital Status: (Circle) Single Married Divorced Widowed

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 #:_____

REASON FOR TODAY'S VISIT

Is this and accident that occurred during school sports? YES / NO If yes, Date of Injury: _____

Is this a Workers' Compensation accident? YES / NO If yes, Date of Injury: _____

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? Right or Left _____ Date of Injury/Onset of Pain: _____

Height: _____ Weight: _____

Who referred you to this practice? _____

INSURANCE INFORMATION–PLEASE PROVIDE CARD SO WE MAY SCAN A COPY
Insurance is filed as a courtesy. Co-payments are collected at the time of services.

Primary Insurance: _____ Secondary Insurance: _____

Please specify if you are the Primary Card Holder or Dependent covered under this insurance plan.

Primary Name (if other than patient):_____ Primary Date of Birth: _____

Primary Address: _____ Relation to Patient: _____

Primary Social Security #:_____

Primary 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)

_____

_____

Do you smoke? NO YES Packs per day_____

Do you drink alcohol? NO YES How often_____

Use Illegal (street) drugs? NO YES What? _____

PLEASE LIST YOUR FAMILY PHYSICIAN OR INTERNIST: _____

PHARMACY NAME: _____ADDRESS: _____

For Physician use only
Date Reviewed:
1._____
2._____

Medical History
Review of Systems

Please check any box that applies to your current medical condition.

Constitutional

- ☐ Fatigue
- ☐ Recent Illness
- ☐ Fever
- ☐ Weight Loss

Ear/Nose/Throat/Neck

- ☐ Headache
- ☐ Neck Swelling
- ☐ Oral Pain

Cardiovascular

- ☐ Arrhythmia
- ☐ Palpitations
- ☐ Chest Pain/Pressure
- ☐ Shortness of Breath
- ☐ Edema
- ☐ Exercise Intolerance
- ☐ Fatigue
- ☐ Near-Syncope/Dizziness

Respiratory

- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Gastrointestinal

- ☐ Gastroesophageal Reflux
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea

Musculoskeletal

- ☐ Stiffness
- ☐ Swelling
- ☐ Generalized Joint Pain
- ☐ Muscle Weakness
- ☐ Back Pain

Neurological

- ☐ Dizziness
- ☐ Paresis
- ☐ Seizure
- ☐ Speech Difficulties
- ☐ Vertigo
- ☐ Weakness

Psychiatric

- ☐ Depression
- ☐ Disturbances of Consciousness
- ☐ Disturbances of Memory

Endocrine

- ☐ Frequent Urination
- ☐ Hot/Cold Intolerance
- ☐ Flushing

Hematological/Lymphatic

- ☐ Abnormal Bleeding/Bruising

Abilene Sports Medicine & Orthopedics
Office Notices

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 at 325-698-3865.

Insurance: Please bring your current insurance card and picture ID. We will make a copy 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.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice or 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.

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 to privacy may be compromised.

I give permission for Abilene Sports Medicine & Orthopedics to discuss any and all medical treatment to the following person. I understand I may revoke this authorization at any time.

Name: _____ Relationship: _____

Assignment of Insurance Benefits

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.

Disclosure Statement

The physicians of Abilene Sports Medicine & Orthopedics (Drs. Dale Funk, Clifford DePrang and Samuel Maroney) acknowledge that they have a financial relationship in the following businesses.

Medical Diagnostic Imaging of Abilene
Abilene Center for Orthopedic and Multispecialty Surgery
Odyssey Health Solutions
Medoc Health Services
Texas Midwest Surgery Center
Salutaris Lab

I acknowledge that I have read and agree with all the above information:

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