

WELCOME TO BIRMINGHAM ORTHOPAEDICS & SPORTS MEDICINE, P.L.L.C.

DATE: _____

PATIENT INFORMATION:

YOUR NAME: (Last) _____ (First) _____ (Middle) _____

HOME ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: (Home) _____ (Cell) _____ (Work) _____

BIRTHDATE: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

SEX: Male Female MARITAL STATUS: Single Married Divorced Widowed

OCCUPATION: _____ SOCIAL SECURITY NO: _____

EMPLOYER: _____

EMPLOYER'S ADDRESS: _____ CITY/STATE/ZIP: _____

IN CASE OF EMERGENCY, CONTACT: _____ RELATIONSHIP: _____

HOME PHONE: (____) _____ WORK PHONE: (____) _____

WHO REFERRED YOU TO US? _____

REFERRING PHYSICIAN: _____ FAMILY PHYSICIAN _____

ADDRESS: _____ ADDRESS: _____

CITY/STATE/ZIP: _____ CITY/STATE/ZIP: _____

PHONE: (____) _____ PHONE: (____) _____

SPOUSE: _____ BIRTHDATE: _____ AGE: _____

SPOUSE'S EMPLOYER: _____ SOCIAL SECURITY NO: _____

EMPLOYER'S ADDRESS: _____

REASON FOR APPOINTMENT: _____

WHAT BODY PART? _____ RIGHT LEFT

DID YOU BRING X-RAYS WITH YOU TODAY? YES NO

ONSET DATE (if injury, see below): _____

INJURIES AND ACCIDENTS:

WERE YOU INJURED AT WORK? YES NO

IN AN AUTO ACCIDENT? YES NO

IS AN ATTORNEY INVOLVED? YES NO

DATE OF INJURY: _____

DATE LAST WORKED: _____

ATTORNEY'S NAME: _____

PHONE: (____) _____

EXPLAIN IN YOUR OWN WORDS HOW THIS INJURY OCCURRED: _____

WHAT TREATMENT HAVE YOU HAD? _____

COMPLETE ONLY IF PATIENT IS CHILD

MOTHER: _____ **BIRTHDATE:** _____ **AGE:** _____

ADDRESS (if different from patient) _____

EMPLOYER: _____ **SOCIAL SECURITY NO:** _____

EMPLOYER ADDRESS: _____

FATHER: _____ **BIRTHDATE:** _____ **AGE:** _____

ADDRESS (If different from patient) _____

EMPLOYER: _____ **SOCIAL SECURITY NO:** _____

EMPLOYER'S ADDRESS: _____

INSURANCE INFORMATION

PLEASE GIVE YOUR CARD TO THE RECEPTIONIST TO COPY

PRIMARY INSURANCE:

NAME OF INSURANCE CO: _____ PHONE: (____) _____

SUBSCRIBER: _____ SUBSCRIBER RELATIONSHIP TO PATIENT: _____

SUBSCRIBER'S BIRTHDATE: _____ SUBSCRIBER'S SS# _____

SUBSCRIBER'S ADDRESS (IF DIFFERENT FROM PATIENT) _____

SUBSCRIBER'S EMPLOYER: _____

SECONDARY INSURANCE:

NAME OF INSURANCE CO: _____ PHONE: (____) _____

SUBSCRIBER: _____ SUBSCRIBER RELATIONSHIP TO PATIENT: _____

SUBSCRIBER'S BIRTHDATE: _____ SUBSCRIBER'S SS# _____

SUBSCRIBER'S ADDRESS (IF DIFFERENT FROM PATIENT) _____

SUBSCRIBER'S EMPLOYER: _____

PLEASE READ AND SIGN BELOW

All HMO's require a written referral or prior authorization for each visit. This is your responsibility. If you do not have this authorization or referral, your appointment may have to be rescheduled, or you will have to contact your primary care physician for approval of services prior to seeing our doctor. If you choose to see the physician without a referral, then you will be responsible for payment.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I represent that I have insurance coverage and do hereby authorize my carrier to pay and assign directly to Birmingham Orthopaedics & Sports Medicine, P.L.L.C. all benefits otherwise payable to me for the service described. I understand that I am accepting responsibility for any part and all of the charges for services provided if my insurance company(ies) do(es) not reimburse the physicians or myself. If payment is sent directly to me, I will promptly submit the same to Birmingham Orthopaedics & Sports Medicine, P.L.L.C.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Birmingham Orthopaedics & Sports Medicine, P.L.L.C. to release in writing or orally, any records and information including any relating to my medical case to my employer, compensation carrier, rehabilitation specialist and physician who was/or is, now/or in the future evaluating or treating me. I authorize release of a narrative report relating to my office visits to my referring physician.

SIGNATURE: _____ **DATE:** _____

TELL US ABOUT YOURSELF AND YOUR MEDICAL HISTORY:

Patient: _____

Date: _____

Circle anything listed below to which you are allergic:

- | | |
|------------------------|----------------------------|
| (A) No known allergies | (G) Codeine |
| (B) Penicillin | (H) Iodine/Betadine |
| (C) Tetracycline | (I) Radiographic dyes |
| (D) Sulfa | (J) Adhesive tape |
| (E) Morphine | (K) Other (specify): _____ |
| (F) Erythromycin | |

What medicines are you currently taking? Please include both prescription and non-prescription medications.

Medications	Dose	# Times a Day

TELL US ABOUT YOUR HEALTH IN GENERAL: Do you have any of the following? Circle YES or NO.

SYMPTOMS

COMMENTS

SYMPTOMS	Yes	No	COMMENTS
Chest pain	Yes	No	_____
Dizziness	Yes	No	_____
Dry cough	Yes	No	_____
Productive cough	Yes	No	_____
Difficulty breathing	Yes	No	_____
Irregular heartbeat	Yes	No	_____
Swelling in the legs	Yes	No	_____
Lack of appetite	Yes	No	_____
Increase in appetite	Yes	No	_____
Nausea	Yes	No	_____
Vomiting	Yes	No	_____
Diarrhea	Yes	No	_____
Constipation	Yes	No	_____
Abdominal cramping	Yes	No	_____
Varicose veins	Yes	No	_____
Bruising	Yes	No	_____
Bleeding	Yes	No	_____
Nose bleeds	Yes	No	_____
Joint pain and/or stiffness	Yes	No	_____
Muscle pain or muscle cramps	Yes	No	_____
Difficulty seeing	Yes	No	_____
Difficulty hearing	Yes	No	_____
Difficulty swallowing	Yes	No	_____
Difficulty sleeping	Yes	No	_____
Date of last menstrual period: _____			Is there any chance you could be pregnant today? <input type="checkbox"/> Yes <input type="checkbox"/> No

Circle any of the medical problems listed below that you have now:

- | | |
|--------------------------------------|---------------------------------|
| (A) I have no known medical problems | (L) Immune disorder |
| (B) Arthritis | (M) Liver disease |
| __ Rheumatoid | (N) Osteomyelitis |
| __ Other | (O) Overweight |
| (C) Asthma | (P) Past heart attack |
| (D) Cancer | (Q) Peripheral vascular disease |
| (E) COPD/Lung problem | (R) Seizure disorder |
| (F) Coronary artery disease | (S) Thyroid disease |
| (G) Diabetes | (T) Tuberculosis |
| __ Adult | (U) Ulcers |
| __ Juvenile | (V) Other: |
| (H) Emphysema | _____ |
| (I) Gout | _____ |
| (J) Hepatitis | _____ |
| (K) Hypertension | _____ |

Are you (circle one): Right handed Left handed Both

How much alcohol do you consume?

- | | |
|--------------------------------|--------------------------------------|
| (A) I'm a non-drinker | (E) An average of 1-2 drinks per day |
| (B) I'm a recovering alcoholic | (F) An average of 2-3 drinks per day |
| (C) I drink only occasionally | (G) An average of 3-4 drinks per day |
| (D) I drink weekends only | (H) More than 6 drinks per day |

Do you now, or have you ever smoked cigarettes?

- (A) Yes, I am currently a smoker
I smoke (circle one) 1 2 3 packs per day
I have smoked for _____ years.
- (B) No, but I used to smoke. I smoked for _____ years.
- (C) No, I have never smoked.

Do you now, or have you ever used drugs?

- | | |
|------------------|----------------------------|
| (A) Recreational | (C) Marijuana |
| (B) Cocaine | (D) Other (specify): _____ |

Has anyone in your immediate family ever had any of the following? Circle the illness(es) that apply:

- | | |
|-----------------------------|----------------------------|
| (A) None known | (I) Hypothyroidism |
| (B) Cancer | (J) Colitis |
| (C) Leukemia | (K) Bleeding tendency |
| (D) Stroke | (L) Asthma |
| (E) Hypertension | (M) Tuberculosis |
| (F) Coronary artery disease | (N) Seizure disorder |
| (G) Rheumatic fever | (O) Alcoholism |
| (H) Diabetes | (P) Other (specify): _____ |

Circle any of the surgeries listed below you may have had. Indicate the year of your surgery:

- | | |
|---------------------------------|------------------------------|
| (A) No previous surgeries _____ | (G) Hysterectomy _____ |
| (B) Appendectomy _____ | (H) Lumbar laminectomy _____ |
| (C) Cataract extraction _____ | (I) Mastectomy _____ |
| (D) Bypass/Open heart _____ | (J) Tonsillectomy _____ |
| (E) Gallbladder _____ | (K) Prostate surgery _____ |
| (F) Hernia repair _____ | (L) Other (specify): _____ |

Any previous broken bones or orthopaedic procedures? Yes No Blood transfusions? Yes No