Patient History

Reason for Today's Visit_____

PAIN ASSESSMENT:

Date your pain began_____ What happened? _____

Is this pain from a work- related injury? _____

Were you seen in ER? _____ Where? _____ Were x-rays made? _____

Have you been treated by another doctor for this same condition? _____ Who? _____

What treatment did you receive? _____

How many hours per day are you in pain? _____ When is your pain worse AM? PM? _____

What activities or daily functions make your pain worse? _____

Does pain interrupt your sleep? _____

What have you tried to reduce your pain? _____

What has helped most to reduce your pain? _____

Any weakness? _____ Numbness? _____

Any changes in your bowel or bladder habits? _____

REVIEW OF SYSTEMS: circle any of the following problems you have

CVR Heart attack shortness of breath high blood pressure

GI: blood in urine increased frequency of urination

GI: abdominal pain ulcers vomiting blood blood in stool jaundice hepatitis

Recent weight loss? _____ How much? _____ in how long? _____

PAST MEDICAL HISTORY: Who is your primary care physician or general medical doctor? _____

List any serious illnesses you have: (i.e. diabetes, cancer, seizures, free bleeding).

_____

List your drug allergies: _____

List your current medications:

_____

_____

Have you had any previous spine surgery? _____ if yes, please list _____

List any other type surgeries? _____

Any problems with Anesthesia: _____

SOCIAL HISTORY: circle answer

Do you smoke? Yes / No What? And How much? _____ / day for _____ yrs.

Describe your alcohol consumption: Never Rarely Daily How much per day? _____

FAMILY HISTORY

Any known genetic or hereditary type diseases from your family? Yes / No

Mother's illnesses _____ Father's Illnesses _____

Patient Pain Drawing

DATE: _____

AGE: _____

SEX: _____

WT: _____ LBS

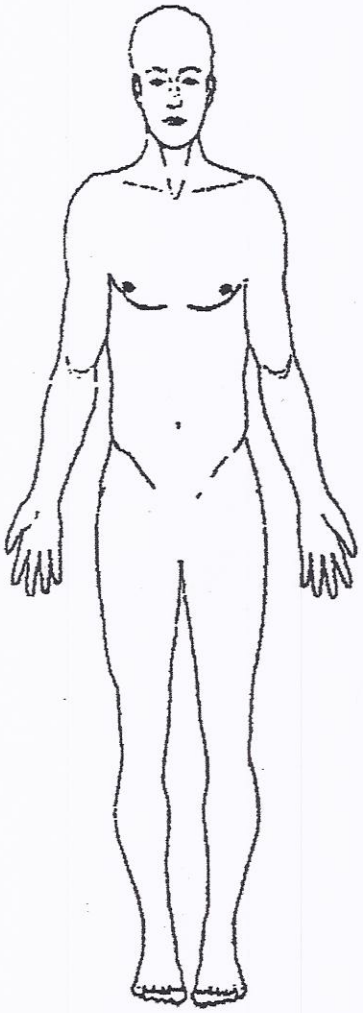
Ht. _____ FT. _____ IN.

Patient Name: _____

Patient Signature: _____

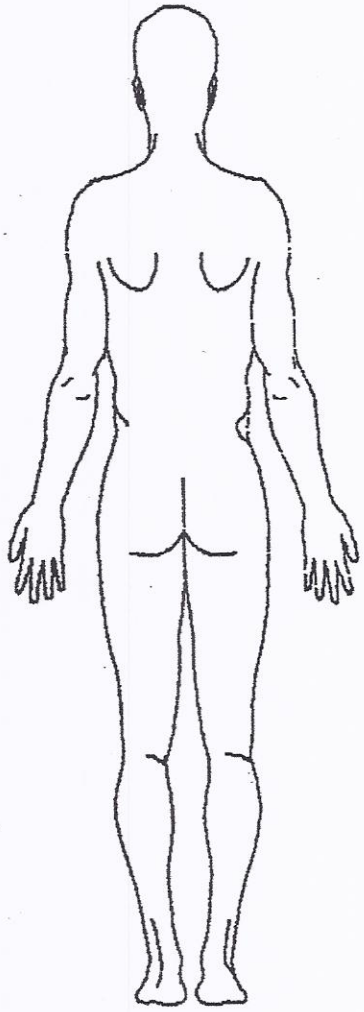
Using the symbols below, please draw your pain on the diagrams below:

FRONT



Right Left

BACK



Left Right

Stabbing Pain	Burning Pain	Aching Pain	Pins & Needles	Numbness
//////	ooooo	xxxxx	++++	-------

Circle your pain level on a scale of 1 to 10, with 10 being unbearable or the worst imaginable pain.

(no pain) 1 2 3 4 5 6 7 8 9 10 (extreme pain)

D1 Orthopedic Sports Medicine

1651 Independence Ct, Suite 211*Birmingham, AL 35209* (205) 803-3700

PATIENT AUTHORIZATION TO RELEASE INFORMATION & ASSIGN BENEFITS

I hereby authorize D1 Orthopedic Sports Medicine to release any information in the course of my examination or treatment to any insurer or government agency providing benefits for me. I further authorize payment directly to the physician(s) of all benefits payable under the terms of my insurance policy and agree to pay the difference of the bill including any co-pays due at time of treatment. In the event this account is turned over to a collection agency or attorney for collections, I shall additionally pay all costs of collections, including reasonable attorney's fees.

SIGNATURE OF PATIENT/LEGAL GUARDIAN: _____ (Additional forms required for Medicare and Medicaid Patients)

PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received a copy of D1 Orthopedic Sports Medicine Notice of Privacy Practices:

SIGNATURE: _____ **DATE**: _____

I also authorize D1 Orthopedic Sports Medicine to disclose and/or release my protected health information to the following (Please select all that apply and list names where applicable.)

- ☐ **Spouse**: _____
- ☐ **Child**: _____
- ☐ **Child:** _____
- ☐ **Doctor**: _____
- ☐ **Friend**: _____
- ☐ **Other**: _____
- ☐ **Other:** _____
- ☐ **I do not want my information given to anyone**

Is it okay to leave information on an answering machine and/or voicemail: ☐ Yes ☐ No - only speak directly to me

FORMS, CHARTS NOTES, XRAY CD & MRI CD

There is a $30.00 prepaid fee for completing patient forms. The minimum time for completion of these forms is ten (10) business days.

Copying of chart notes or records is subject to the following rates:

$5.00 search fee plus $1.00 per page, up to 25 pages, then $.50 per page up to 50 pages. After 50 pages, the per page charge is $.25.

X-Ray & MRI copying fee is & 10.00 per CD. A two (2) day prior notice is required for this service and cannot be done on Mondays or Wednesdays.

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PATIENT NAME: (FIRST, MIDDLE, LAST)	SEX: M F	BIRTHDATE:	AGE:	MARITAL STATUS: S M D W	SOCIAL SECURITY #:
HOME PHONE: ( )	CELL PHONE: ( )	WORK: ( )	E-MAIL:		
PATIENT'S **PHYSICAL** ADDRESS: (STREET, CITY, STATE, ZIP CODE)					
PATIENT'S **MAILING** ADDRESS: (STREET, CITY, STATE, ZIP CODE)					
EMPLOYER:	OCCUPATION:	YEARS EMPLOYED?			
ARE YOU A STUDENT? YES NO	FULL TIME? YES NO	PART TIME? YES NO	SCHOOL NAME:		
PREFERRED PHARMACY:	PHARMACY ADDRESS:	PHARMACY PHONE:			
SPOUSE'S NAME:	ADDRESS: (IF DIFFERENT FROM ABOVE, IF NOT WRITE "SAME")	SPOUSE'S SS#:			
SPOUSE'S EMPLOYER	OCCUPATION:	WORK PHONE: ( )	BIRTHDATE:	ARE YOU ON HIS/HER INS.? Y N	
EMERGENCY CONTACT:	RELATIONSHIP:	PHONE: (NOT YOURS) ( )	ADDRESS:		
REFERRING PHYSICIAN:	ADDRESS OR LOCATION:	PHONE: ( )			

COMPLETE THIS SECTION IF PATIENT IS A MINOR OR STUDENT:

FATHER'S NAME:	ADDRESS: (IF DIFFERENT FROM ABOVE. IF NOT, WRITE "SAME")	HOME PHONE: ( )		
FATHER'S EMPLOYER:	OCCUPATION:	WORK PHONE: ( )	SOCIAL SECURITY #:	
FATHER'S BIRTHDATE:	IS MINOR ON FATHER'S INSURANCE? Y N	MOTHER'S BIRTHDATE:	IS MINOR ON MOTHER'S INSURANCE? Y N	
MOTHER'S NAME:	ADDRESS: (IF DIFFERENT FROM ABOVE. IF NOT, WRITE "SAME")	HOME PHONE: ( )		
MOTHER'S EMPLOYER:	OCCUPATION:	WORK PHONE: ( )	SOCIAL SECURITY #:	

RESPONSIBLE PARTY AND INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT:	RELATIONSHIP:	ADDRESS: (IF DIFFERENT FROM ABOVE. IF NOT, WRITE "SAME")	HOME PHONE: ( )	
NAME OF **PRIMARY** INSURANCE:	INSURED'S NAME:	CONTRACT#:	GROUP #:	COVERAGE CODE:
NAME OF **SECONDARY** INSURANCE:	INSURED'S NAME:	CONTACT #:	GROUP #:	COVERAGE CODE:

D1 Sports Medicine has my permission to bill my insurance. SIGN: _____ DATE: _____