



Southwest Sports Medicine and Orthopaedic Surgery Clinic, LTD.

Date: _____

Guarantor: _____

Name: _____

Name: _____

Address: _____

Address: _____

DOB: _____ Sex: _____

DOB: _____ Sex: _____

Home Phone: _____

Home Phone: _____

Cell: _____

Cell: _____

Email: _____

Emergency Contact: Name: _____

Phone: _____

Insurance: Yes: ___ No: ___

Primary: _____

Secondary: _____

Address: _____

Address: _____

Patient Insurance Coverage Responsibility Disclaimer and Authorization

I understand that it is my responsibility to know if Southwest Sports Medicine is an authorized provider according to my insurance contract. If for any reason my insurance contract is not valid or any fees are not covered by my insurance contract, I am responsible for payment of all charges. I also understand that Southwest Sports Medicine may collect from me any co-payment, balance and percentage due by insurance contract at time of service.

I understand that I am responsible to know which lab and outside facilities my insurance company utilizes for all lab work, diagnostic testing and specialist's appointments. If prior authorizations are required by my insurance contract for diagnostic testing and specialists' appointments, I realize that it is my responsibility to request a referral authorization from my primary care provider. Failure to do so may result in my insurance company denying payment for services and I will be responsible for the services performed.

I authorize my insurance company to pay all benefits directly to Southwest Sports Medicine and thereby agree to the release of relevant medical information to insurance carriers.

Signature of Patient or Guarantor: _____

No Show/ Cancellation and Surgical Coverage Responsibility Disclaimer:

No show: I understand that a \$25.00 fee will be charged to my account if I neglect to cancel my appointment 24 hrs prior to my scheduled appointment.

Surgical Cancellation Fee: I understand that any surgical procedure must be cancelled **NO LATER than 7 calendar days prior to the Date of Surgery or an administrative charge of \$100.00 will be assessed to my account.**

Signature: _____ Date: _____



Authorization for Medical Treatment

This release and consent gives Southwest Sports Medicine, permission to administer medical treatment to my child. I understand that every effort will be made to contact me. However, in case of an emergency, if I cannot be reached, I hereby give Southwest Sports Medicine permission to act on my behalf in providing medical treatment by qualified personnel for my child in the event that such treatment is deemed necessary or advisable for my child's health, safety and welfare. I release Southwest Sports Medicine and all medical providers from liability in acting on my behalf in this regard in rendering such medical treatment.

Parent/Guardian: _____ Date: _____

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have read the Notice of Privacy Practices. I understand that Southwest Sports Medicine may, at its discretion, change the terms and conditions of this notice. I understand the content of the Notice of Privacy Practices and will be provided with a copy upon my request. I give Southwest Sports Medicine permission to leave a message on my answering machine or with the following family members regarding reports, or blood work if I am not home when they call. I consent to general treatment, medical procedures, and medications prescribed by Southwest Sports Medicine.

_____ Copy given to patient _____ Patient declined copy

Signature of Patient or Personal Representative: _____

I give permission to disclosure protected health information from my health records, including financial information to the following:

Name: _____

Name: _____

Name: _____

Release of Medication History Authorization

I give Southwest Sports Medicine permission to obtain/retrieve and view my medication history. I understand that this information will be disclosed/divulged as part of my medical record release.

Signature: _____



Southwest Sports Medicine
New Patient Form

Patient Name: _____ DOB: _____ Age: _____ [] Male [] Female

Primary Care Physician: _____ Who referred you to SWSM? _____

Cardiologist: _____ Pharmacy: (phone number) _____

Daily Medications: (please include pain medication, herbal supplements, vitamins, and OTC)

Table with 3 columns: Name, Dosage/Strength, Times Day. Includes three blank rows for medication entry.

Weight _____ Height _____ Latex Allergy: [] Y [] N

Do you have any known allergies? [] Y [] N Please list below:

Table with 4 columns: ALLERGY, REACTION, ALLERGY, REACTION. Includes three blank rows for allergy entry.

PAST MEDICAL HISTORY: Have you ever had any of the following? (Check all that apply)

- List of medical conditions with checkboxes: Aids/HIV, Anemia, Stroke, Blood Clots, Heart Trouble, Hepatitis, High Blood Pressure, Kidney Disease, Sleep Apnea, Heart Attack, Ulcer/Stomach problems/NSAIDS, Cancer Type, Blood Thinners, Diabetes (Insulin, Oral meds).

SURGICAL HISTORY FOR KNEES, SHOULDERS OR ELBOWS:

Table with 5 columns: Procedure/Body Part, Surgeon, Date, City, State. Includes three blank rows for surgical history entry.

FAMILY HISTORY:

Have any of your blood relatives (living or deceased) had any of the following conditions? If so which relative?

- List of family conditions with checkboxes: Diabetes, High blood pressure, Rheumatoid Arthritis, Cancer, Heart disease, None.

SOCIAL HISTORY:

Marital Status: M S D W Domestic Partner

Occupation/Employer: _____

Do you use tobacco? Y N If yes, how many packs per day? _____

Alcohol use: None Occasional Moderate Heavy

Exercise Level: None Occasional Moderate Heavy

Sporting activities/ Hobbies: _____

Dominant Hand: R L Ambidextrous

If Female, are you pregnant? Y N

REVIEW OF SYSTEMS: *Do you have any of the following medical conditions?*

Constitutional Symptoms

- __ Fever
- __ Night Sweats
- __ Weight Gain ____lbs
- __ Weight Loss ____lbs
- __ Exercise Intolerance

Eyes

- __ Dry Eyes
- __ Irritation
- __ Vision Change

Ears/Nose/Throat

Ears:

- __ Difficulty hearing
- __ Ear Pain

Nose:

- __ Frequent nosebleeds
- __ Nose/ Sinus problems

Mouth/Throat:

- __ Sore Throat
- __ Bleeding Gums
- __ Snoring
- __ Dry Mouth
- __ Oral abnormalities
- __ Mouth Ulcer
- __ Teeth abnormalities
- __ Mouth Breather

Endocrine

- __ Fatigue
- __ Increased Thirst
- __ Hair Loss
- __ Increased hair growth
- __ Cold Intolerance

Cardiovascular

- __ Chest pain on exertion
- __ Arm pain on exertion
- __ Shortness of breath when walking
- __ Shortness of breath when lying down
- __ Palpitation
- __ Known heart murmur
- __ Lightheaded on standing

Respiratory

- __ Cough
- __ Wheezing
- __ Shortness of breath
- __ Coughing up blood
- __ Sleep apnea

Gastrointestinal

- __ Abdominal Pain
- __ Vomiting
- __ Change in appetite
- __ Black or Tarry Stools
- __ Frequent Diarrhea
- __ Vomiting blood

Genitourinary

- __ Urinary loss of control
- __ Difficulty Urinating
- __ Urinary Frequency
- __ Hematuria (blood in urine)
- __ Incomplete emptying

Hematologic/Lymphatic

- __ Swollen glands
- __ Easy bruising
- __ Excessive bleeding

Musculoskeletal

- __ Muscle aches
- __ Muscle weakness
- __ Joint Pain
- __ Back Pain

Integumentary (skin)

- __ Abnormal mole
- __ Jaundice
- __ Eczema
- __ Rash
- __ Itching
- __ Dry skin
- __ Growth/Lesion

Neurologic

- __ Loss of consciousness
- __ Weakness
- __ Numbness
- __ Seizures
- __ Dizziness
- __ Frequent/Severe Headaches
- __ Migraines
- __ Restless Leg

Psychiatric

- __ Depression
- __ Mania
- __ Sleep disturbances
- __ Restless sleep
- __ Feeling unsafe in relationship
- __ Alcohol Abuse

Allergic/Immunologic

- __ Runny nose
- __ Sinus pressure
- __ Itching
- __ Hives
- __ Frequent Sneezing

Chief Complaint/ HPI

What body part are you being seen for today? _____ Right Left Bilateral

Please check one: Injury Sports Injury Work Comp Auto accident Re-Injury
 No Injury (onset was Gradual or Sudden) Date/onset of injury or pain? _____

Please explain how injury/pain occurred: _____

Were you seen in the E.R./Urgent care? Y N Where? _____ Date _____

On a scale of 0-10 how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

Is the pain? Sharp Dull Stabbing Throbbing Aching Burning

Does the pain occur? Constantly Intermittently (comes and goes) At night

Do you have? Swelling Bruising Numbness Tingling Weakness Locking
 Giving way Catching

What makes your symptoms worse? Standing Walking Exercise Twisting Kneeling
 Squatting Lying in bed Stairs Sitting

Which make your symptoms better? Rest Elevation Ice Heat Other: _____

Have you had any of these treatments/tests?

Injection? Y N When? _____ Did it help? Y N

Physical Therapy? Y N When? _____ How often? _____ Did it help? Y N

X-Rays? Y N When? _____ Where? _____

MRI? Y N When? _____ Where? _____

Other: _____

Current work status: Regular Light Duty Not working due to this problem Not working

If work injury date last worked: _____

Are you currently receiving or plan to apply for: Disability Workers Comp Unemployment

PLEASE SIGN: The information provided is accurate to the best of my knowledge.

Signature of Patient or Parent/Legal Guardian of Minor

Date