Current Visit / Insurance Patient Form

Today's Date_________________________

Patient's Name: ____
Last Middle First

Address: ____ City: ________________ State: ______Zip: _________

Home Phone: ___________________Cell Phone: _________________ Work Phone: ________________Ext______

DOB: ________________________ Gender: Male □ Female □ Social Security # ___________________________

Email Address: ____________________________Primary Source of Contact: Home Phone □ Cell Phone □

Driver's License # __________________Employer: ______________________ Work Phone: ___________________

Employer's Address: _______________________________ City: ________________ State: ______ Zip: ________

Whom may we call in Case of Emergency? Name: ____

Relationship to patient: ______________________________ Primary Phone #: ____________________________

Secondary Phone #:____________________________

Referring Physician: ___________________________ Physician's Phone Number: __________________________

<u>Collection Policy</u>: All payments are due at time of services rendered. This practice has a legal obligation to the insurance companies that we are contracted with to collect co-payments, co-insurance and deductibles at time of service. Once a balance reaches 90 days old without payment, it will be transferred to a third party for further collections or other actions. There will be a charge for filling out forms that require more than a signature and $20.00 for writing letters each time these services are provided.

<u>Canceling/Rescheduling An Appointment</u>: If you are unable to keep your appointment, please notify our office at least twenty-four hours in advance to cancel or reschedule your appointment. Your courtesy will allow other patients needing exams the option to use your scheduled appointment time. Patients will be charged $25 for missed appointments unless the appointment was cancelled 24 or more hours in advance. Worker's Compensation patients will be personally responsible for this amount.

<u>What if my child needs to see the Physician</u>: A parent or legal guardian must accompany minor patients on all office visits. This accompanying adult is responsible for payment on the account.

Patient's Initials ____________

Primary Insurance Co.: ____________________________________Insurance Phone: ______________________

Insured Name: ________________________________ DOB: _______________ SS#: ______________________

Patient Relationship to Insured: _________________________________

Insurance ID#:_______________________________________Group#:__________________________________

***Secondary Insurance Co.:** ________________________________ Insurance Phone: ______________________

Insured Name: ________________________________ DOB: ___________SS#:________________________

Patient Relationship to Insured: __________________ Insurance ID# ________________Group# ______________

Consent for Purpose of Treatment, Payment, Healthcare Operations and Notice of Privacy Practices

I consent to the use or disclosure of my protected health information by Orthopaedic Surgery & Sports Medicine of San Antonio, hereby referred to as OSSMSA, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of OSSMSA. I understand that diagnosis or treatment of me by **Andrew L. Whaley, M.D., Krista A. Chapman, PA-C and/or other providers that are employed or contacted with OSSMSA** may be conditioned upon my consent as evidence by my signature on this document. I understand that **Andrew L. Whaley, M.D., Krista A. Chapman, PA-C and/or other providers that are employed or contracted with OSSMSA** may provide care to me in facilities in which they may have a financial interest.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practices. OSSMSA is not required to agree to the restrictions that I may request. However, if OSSMSA agrees to a restriction that I request, the restriction is binding on OSSMSA and

____.
(Write patient's name here)

I have the right to revoke this consent, in writing, at any time, except to the extent that **Andrew L. Whaley, M.D., Krista A. Chapman, PA-C** or OSSMSA has taken action in reliance on the consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review OSSMSA's Notice of Privacy Practices prior to signing this document. The OSSMSA Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the OSSMSA. The Notice of Privacy Practices for OSSMSA is also available at the front desk of each clinic and on the OSSMSA website at **www.ossmsa.com**. This Notice of Privacy Practices also describes my rights and the OSSMSA duties with respect to my protected health information.

OSSMSA reserves the right to change the privacy practices described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing the OSSMSA website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____
Signature of Patient or Personal Representative

____
Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

Orthopaedic Surgery & Sports Medicine OF SAN ANTONIO

ACCIDENT/INJURY QUESTIONNAIRE

Please complete the below information to help us process your claim accordingly and sign below.

Patient's Name:	Date:
DOB:	SSN:

1. Is your visit related to an accident or injury?
   □ Yes □ No

2. a. Was your injury related to an automobile accident?
   □ Yes; Date of Accident: ___/___/______ □ No

   b. If Yes to question above, was another party responsible for this accident?
   □ Yes □ No

3. Was your illness/injury due to a work related accident/condition?
   □ Yes; Date of Injury/Illness: ___/___/_____ □ No

4. a. Is your visit related to any other type of injury/accident?
   □ Yes; Place of Accident: ______________________ □ No

   b. If Yes to question above, was another party responsible for this accident?
   □ Yes □ No

If yes to any of the above, please provide a brief summary of the illness/injury/accident details:

____

____

____

____

Patient's Signature____

Current Visit / Medical History

This questionnaire collects information about your current state of health to assist the medical team with your care and help us meet requirements established by Medicare and other insurers. This information will be stored electronically and reformatted for your medical record. Thank You for filling this information out accurately as it helps us provide you with the best possible care.

Answer ALL questions by filling in the appropriate circle(s) and by PRINTING the requested information in the appropriate box. All unanswered questions will be returned for you to complete prior to your visit with the clinician. Please complete answers by filling in the circles like ●

Today's Date:____

Patient's Name: ______________________________________

1. If any of the above information is incorrect, please inform the receptionist
2. Who completed this form? ○ Self ○ Parent ○ Spouse/Family Member ○ Guardian ○ Other
   If not patient, please write name of person completing form: ______________________________

A. Healthcare Provider Information & Authorization to Release Information

3. Do you have a regular physician?
   ○ No ○ Yes - print name, title, phone and address below:

   Name/Title:_____________________________ Phone: ________________________

   Address: ____

   City/State/Zip: ____

4. Do you wish us to forward information from your visit today to your primary physician? □ Yes □ No

B. Medications

5. Please list any prescription and/or non-prescription medications including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, herbal therapy and cold medications you are currently taking.

   ○ I am not taking any medications

Name of Medication	Dose Strength	How often taken (e.g. 12x per day)	Name of Medication	Dose Strength	How often Taken (e.g. 12x per day)

6. If you are taking more medications than space provided please bring a list to your appointment.

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7. Are there any other medications you have used in the past month and are no longer taking? ○ No ○ Yes
(If yes, please bring a list to your appointment.)

8. Have you taken aspirin containing products in the last two weeks? ○ No ○ Yes

9. Have you taken steroid or cortisone type drugs within the last year? ○ No ○ Yes

10. Do you take antibiotics prior to dental work of any other procedure? ○ No ○ Yes

C. Allergies

11. Are there medications to which you have had an allergic reaction or unpleasant side-effects?
○ No ○ Yes

(If yes, please describe in space below. If more than space allows, bring a list to your appointment.)

Name of Medication	Reaction

12. Have you had an allergic reaction to any of the following? (specify all that apply)

○ Latex ○ Bee or wasp stings ○ Adhesive tape ○ Iodine or X-ray contrast dye
○ Influenza vaccination ○ Other (*Discuss with your care provider)* ○ None

13. Do you have any food allergies? ○ No ○ Yes (***If yes, please bring a list to your appointment.)***

D. Systems Review

Fill in the circle to the left of each symptom that you have experienced in the past few months.
Indicate "NONE"(at the end of the list) if you nave not experienced any of the symptoms listed in each group

14.
○ fever
○ enlarged glands (lymph nodes)
○ breast lump
○ skin rash
○ skin sores
○ hoarseness
○ excessive bruising
○ change of a mole
○ significant headaches
○ seizures
○ slurred speech
○ excessive thirst
○ double vision
○ blurred vision
○ diminished hearing
○ dizziness
○ sinus problems
○ NONE

15. Are you bothered with:
○ shortness of breath
○ wheezing
○ coughing
○ NONE

16. Have you:
○ "blacked out" or lost consciousness
○ awakened at night with shortness of breath
○ been exposed to anyone with tuberculosis (TB)
○ coughed up sputum
○ coughed up blood
○ NONE

17. Have you had:
○ abnormal swelling in the legs or feet
○ pain in the calves of your legs when your walk
○ known difficulty with a heart valve
○ chest pain
○ chest pressure
○ NONE
○ irregular heart beats
○ rapid heart beats

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18. Have you had:
- O difficulty swallowing
- O heartburn
- O nausea
- O vomiting
- O stomach trouble
- O significant problems with constipation
- O significant problems with diarrhea
- O blood in your bowel movements
- O changes in your bowel movements
- O excessive urination
- O burning or pain when urinating
- O difficulty starting your urinary steam
- O difficulty completely emptying your bladder
- O difficulty with leaking urine from your bladder
- O NONE

19. Have you had:
- O joint pain
- O joint stiffness
- O joint swelling
- O muscle pain
- O muscle stiffness
- O back pain
- O back stiffness
- O difficulty moving an arm or leg
- O NONE

20. Have you had:
- O weight gain of more than 10 pounds during the last 10 months
- O weight loss of more than 10 pounds during the last 10 months
- O NONE
- O problems with disruptive snoring
- O problems falling asleep
- O problems staying asleep
- O sleep apnea

Questions 21 to be completed by Female patients ONLY:

21. Number of pregnancies? **(Please circle.)**

1 2 3 4 5 6 7 8 9+

Number of live births? **(Please circle.)**

1 2 3 4 5 6 7 8 9+

Question 22 to be completed by MALE patients ONLY:

22. Have you had a vasectomy?

O No O Yes O Don't Know

E. Self Care/ Home Environment Assessment

23. What are your current living arrangements?

O House O Apartment O Nursing Home Assisted Living O Other

24. Do you live:

O Alone O With Spouse/Family O With others

25. Do you have family/friends or others who are able to provide assistance with your homecare needs if you would ever require such assistance?

O No O Yes

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F. Social History

26. How many years of school have you completed? Record highest level attained. **(Please circle.)**

1 2 3 4 5 6 7 8 9 10 11 12
13 14 15 16 17+

27. Are you currently married?

○ No ○ Yes ***(If yes, indicate spouse's current employment status:)***

○ Retired ○ Unemployed ○ Employed ○ Other
(homemaker,student,vounteer, etc.)

28. Have you been:

○ Divorced ○ Widow/Widower In the past year? ○ No ○ Yes

29. What is your current employment status? Occupation:________________________

○ Retired ○ Unemployed ○ Employed ○ Other
(homemaker,student,vounteer, etc.)

30. Are you disabled?

○ No ○ Yes

G. Substance Review

31. Alcohol ○ NONE

	Number of days per week		**Number of servings per day**			**Number of years used**			
Current Use	0-2	3-7	1-2	3-4	5-10+	1-3	4-6	7-10	10+
Previous Use	0-2	3-7	1-2	3-4					

32. Cigarettes ○ NONE

	Number of days per week		**Number of packs per day**			**Number of years used**			
Current Use	0-2	3-7	1-2	3-4	5-10+	1-3	4-6	7-10	10+
Previous Use	0-2	3-7	1-2	3-4					

33. Other Tobacco ○ NONE

Number of years used	1-5	6-10	11-15	16-30	30+
Pipe					
Cigar					
Smokeless/Chew/Snuff					

H. Past Medical History

34. Have you ever traveled or lived outside the United States or Canada?

○ Don't know ○ No ○ Yes

35. Have you ever received a blood transfusion?

○ Don't know ○ No ○ Yes ***(If yes, check all that apply.)***

○ Before 1980 ○ 1980-1990 ○ After 1990

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Indicate whether you have ever sought medical care or had a medical problem or surgery related to each of the following. Indicate "No Problem" when appropriate. More than one answer may apply.

	NO PROBLEM	MEDICAL PROBLEM	SURGERY
Eyes			
Ears			
Nose			
Sinuses			
Tonsils			
Thyroid or parathyroid gland			
Arteries (heard arms legs, aorta, etc.)			
Veins or blood clots in the veins			
Heart attack			
Heart valves			
Abnormal heart rhythm			
Narrowed coronary arteries			
Pacemaker Placement Lungs			
Esophagus (food or swallowing pipe)			
Diabetes			
Stomach (ulcer)			
HTN Hypertension/ high blood pressure			
Asthma/ COPD			
Bowel (small or large intestines, rectum)			
Appendix			
Lymph nodes			
Spleen			
Liver			
Gallbladder			
Pancreas			
Hernia			
Kidneys			
Bladder			
Bones (what type)			
Muscles			
Back			
Neck			
Brain			
Breasts			
Other			

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		NO PROBLEM	MEDICAL PROBLEM	SURGERY
Females:	Uterus	O	O	O
	Ovaries Fallopian	O	O	O
	tubes	O	O	O
	Hysterectomy	O	O	O
	Other	O	O	O
Male	Prostate	O	O	O
	Penis	O	O	O
	Testicles	O	O	O
	Vasectomy	O	O	O
	Other	O	O	O

I. Personal and Family History

36. Are you adopted? O No O Yes

37. If known, complete the following information about your blood relatives (include children).

Father
O Don't know
O Alive
O Deceased - Age at death
O Under 30 O 51-60
O 30-40 O 61-70
O 41-50 O Over 70

Mother
O Don't know
O Alive
O Deceased - Age at death
O Under 30 O 51-60
O 30-40 O 61-70
O 41-50 O Over 70

Brothers	0	1	2	3	4	5	6	7+	Don't Know
Number alive:	O	O	O	O	O	O	O	O	O
Number deceased:	O	O	O	O	O	O	O	O	

Sisters	0	1	2	3	4	5	6	7+	Don't Know
Number alive:	O	O	O	O	O	O	O	O	O
Number deceased:	O	O	O	O	O	O	O	O	

Sons	0	1	2	3	4	5	6	7+	Don't Know
Number alive:	O	O	O	O	O	O	O	O	O
Number deceased:	O	O	O	O	O	O	O	O	

Daughters	0	1	2	3	4	5	6	7+	Don't Know
Number alive:	O	O	O	O	O	O	O	O	O
Number deceased:	O	O	O	O	O	O	O	O	

Provider's signature________________ Date ________________

Staff's Initials __________