PLEASE PRINT LEGIBLY AND COMPLETE ALL INFORMATION

Patient Information

Patient Name:	Date of Birth:	Age:	Social Security #:
Address:	City:	State:	Zip:
Home Phone #:	Cell Phone #:	Gender: ☐ Male ☐ Female	
Race: ☐ American Indian ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other:			
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Email Address:		
Employer:	Occupation:	Work Phone #:	

Notice: We use an automated phone system to send appointment reminders to our patients. If you prefer not to receive appointment reminders, please indicate so. ☐ I DO NOT WANT APPOINTMENT REMINDERS

Is your injury sports or school-related? ☐ Yes ☐ No If you checked *Yes*: School: ______________ Date of Injury: ____________

Is your injury work-related? ☐ Yes ☐ No If you checked *Yes*, are you filing a Workers' Comp claim? ☐ Yes ☐ No

Responsible party if different from patient:

Name:	Address:		
City:	State:	Zip:	Phone #:

Emergency Contact:

Name:	Relationship:	Phone #:

Insurance Information

Primary Insurance:		Group/Policy #:	
Policyholder's Name:	DOB:	SS #:	ID # on Card:
Relationship of the patient to holder: ☐ Myself ☐ Spouse ☐ Child/Dependent			
Secondary Insurance:		Group/Policy #:	
Policyholder's Name:	DOB:	SS #:	ID # on Card:
Relationship of the patient to holder: ☐ Myself ☐ Spouse ☐ Child/Dependent			

ASSIGNMENT OF BENEFITS

I authorize Cornerstone Sports Medicine to provide information to insurance carriers concerning me and/or my dependent's health conditions and treatments, and I assign to the physician(s) all payments for medical services provided to myself or those over whom I have guardianship. I understand and agree that regardless of my insurance, I am ultimately responsible for the remaining balance on my account and/or my dependents for any professional services provided. I understand that I am accountable for any outstanding amount not covered by insurance. I certify that the information I have provided to Cornerstone Sports Medicine is correct and accurate to the best of my knowledge and I will notify the appropriate personnel at Cornerstone Sports Medicine of any changes of which they should be made aware.

If our office is not currently contracted with your insurance company, please speak with us. We will provide information to you sufficient for you to file a claim with your insurance company if necessary.

Patient's Signature (or Guardian):____ Date: ____

Patient Privacy Notice (HIPAA Form) and Authorization to Treat a Minor

The Notice of Privacy Practices provides information about how we may use and disclose protected health information. Protected health information includes any information pertaining to our patients' health condition that is maintained by Cornerstone Sports Medicine that could be used to identify said individuals.

You have the right to review our notice before signing this consent. This facility uses your protected health information for purposes of providing treatment, obtaining payment for treatment and conducting health care operations.

***NOTE*:** If the patient is a minor (under 18 years of age), his/her parent/guardian must read and sign to give permission for treatment below.

Please list below the individuals you give permission to access your protected health information:

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

By signing this form, you consent to our use and disclosure of your protected health information. You have the right to revoke this consent to us in writing, except where we have already made disclosure according to your prior consent.

Patient Name: ______________________________ Signature of Patient (or Guardian): ______________________________

Guardian Name: ______________________________ Date: ______________________________

Authorization to Treat a Minor

I hereby give permission to providers and staff of Cornerstone Sports Medicine to provide evaluation and treatment (which may include x-rays) to the individual who is a minor over which I have legal guardianship.

Signature of Parent or Guardian:______________________________ Date: ______________________________

External Medication Consent Form

Patient medication history is a list of prescription medications that our practice's providers, or other providers, have prescribed for you. This information is aggregated into your electronic health record (EHR). Medication history is very vital for us to understand how we can best help treat your illness or injury properly while avoiding potentially dangerous drug interactions.

Please make sure to discuss your list of medications with your healthcare providers to ensure all mediations are included.

I give permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

Signature of Parent or Guardian:___________________________________ **Date:** ___________________________________

Social History Substance Questionnaire

1. **How often do you have a drink containing alcohol?**
   - ☐ Never
   - ☐ Monthly or less
   - ☐ 2-4 times a month
   - ☐ 2-3 times a week
   - ☐ 4 or more times a week

2. **How many drinks did you have on a typical day in the past year?**
   - ☐ None
   - ☐ 1 or 2
   - ☐ 3 or 4
   - ☐ 5 or 6
   - ☐ 7 or 8
   - ☐ 9 or more

3. **How often do you have six or more drinks in a single occasion?**
   - ☐ Never
   - ☐ Less than monthly
   - ☐ Monthly
   - ☐ Weekly
   - ☐ Daily or almost daily

4. **Have you ever used tobacco?**
   - ☐ Yes
   - ☐ No

   If yes**, what type?** _________________
   If yes**, frequency?** _________________

5. **Are you a former smoker?**
   - ☐ Yes
   - ☐ No

   If yes**, when did you quit?** __________

6. **Are you regularly exposed to secondhand smoke?**
   - ☐ Yes
   - ☐ No

7. **Do you use recreational drugs?**
   - ☐ Yes
   - ☐ No

Full Name ______________________________________ **Date of Birth** ______________ **Appointment Date** ____________

Pharmacy Preference (include location) ____

Name of Primary Care (Family) Physician _________________________ **Referred by** ______________________________

What is the reason you are seeing the doctor today? ____

Height _______________ **Weight** _________________

Have you fallen in the last year? ☐ **Yes** ☐ **No** **If yes, did you sustain any injuries from your fall?** ☐ **Yes** ☐ **No**

CURRENT MEDICATIONS:
Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications)
☐ **Yes** ☐ **No** **If yes, please list below and *include dosages*.**

Medication	Dose	How often taken

MEDICATION ALLERGIES: **ARE YOU ALLERGIC TO ANY MEDICATIONS?** ☐ **Yes** ☐ **No** **If yes, please list below.**

Medication	Reaction (Hives, Anaphylaxis, Rash, Stomach Upset, Dizziness)

PAST MEDICAL HISTORY

Please circle all that apply.

Hypertension	HIV/AIDS	Headaches	Hepatitis A
Diabetes	Lung Disease	Eye Disorder	Hepatitis B
Heart Disease	Sleep Apnea	Glaucoma	Hepatitis C
Pacemaker	Stroke	Depression	Liver Disease
Arthritis	Seizures	Anxiety	Other:
Thyroid Disorder	Concussions	GERD	Other:
Bleeding Disorder	Migraines	Stomach Problems	

ARE YOUR IMMUNIZATIONS CURRENT? ☐ **YES** ☐ **NO**

SURGERIES:

Date	Surgery

Have you ever had any problems with anesthesia (put to sleep/awaking from anesthesia)? ☐ **Yes** ☐ **No**
If **yes**, please describe what sort of problems. ____

Have you been hospitalized for a non-surgical problem before? ☐ **Yes** ☐ **No**
If **yes**, list hospitalizations, the reason for admission and the date in the table below.

HOSPITALIZATIONS:

Date	Reason for Hospitalization

FAMILY HISTORY

Please check all that apply. For mental illness and cancer, please specify in the indicated box marked with **.

	Diabetes	*Hypertension*	*Heart Disease*	*Stroke*	*Mental Illness***	*Cancer***	*Arthritis*
Father	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐

*** Please specify:*____

Check here if family history is unknown: ☐

REVIEW OF SYMPTOMS

Please check all that apply

General Health Problems: ☐ No ☐ Yes

- ☐ Fever
- ☐ Sleeping problems
- ☐ Headaches
- ☐ Unintentional weight loss
- ☐ Unintentional weight gain

Eye Problems: ☐ No ☐ Yes

- ☐ Double vision
- ☐ Itchy eyes

Ear Problems: ☐ No ☐ Yes

- ☐ Ear pain
- ☐ Ear drainage
- ☐ Hearing loss
- ☐ Dizziness
- ☐ Ringing

Nose & Sinus Problems: ☐ No ☐ Yes

- ☐ Chronic congestion
- ☐ Hay fever
- ☐ Post nasal drainage

Mouth & Throat Problems: ☐ No ☐ Yes

- ☐ Change in voice
- ☐ Snoring
- ☐ Sore throat
- ☐ Ulcers

Heart or Blood Vessel Problems: ☐ No ☐ Yes

- ☐ Blacking out or fainting
- ☐ Bluish discoloration of lips or fingernails
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Leg cramps
- ☐ Swelling of ankles

Lung or Respiratory Problems: ☐ No ☐ Yes

- ☐ Frequent non-productive cough
- ☐ Frequent productive cough
- ☐ Shortness of breath
- ☐ Wheezing

Muscle or Bone Problems: ☐ No ☐ Yes
circle side of pain when prompted

- ☐ Muscle pain
- ☐ Back pain
- ☐ Cramping
- ☐ Popping joints
- ☐ Stiffness in joints
- ☐ Bruising
- ☐ **R / L / Bilateral** Shoulder pain
- ☐ **R / L / Bilateral** Knee pain
- ☐ **R / L / Bilateral** Ankle pain
- ☐ **R / L / Bilateral** Hand/wrist pain
- ☐ **R / L / Bilateral** Hip pain
- ☐ **R / L / Bilateral** Elbow pain
- ☐ Other: ___________

Stomach (Gastrointestinal): ☐No ☐ Yes

- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea,
- ☐ Vomiting

Brain or Nervous System Problems: ☐ No ☐ Yes

- ☐ Numbness
- ☐ Seizures
- ☐ Severe face pain
- ☐ Weakness

Problems with Glands, Hormones: ☐No ☐ Yes

- ☐ Feel cold all the time
- ☐ Feel hot when others do not
- ☐ Increased appetite
- ☐ Increased fatigue
- ☐ Neck has enlarged
- ☐ Unwanted weight change

Blood or Lymph nodes Problems: ☐ No ☐ Yes

- ☐ Bleeds excessively after injury
- ☐ Bruises easily

Problems with Allergies: ☐ No ☐ Yes

- ☐ Food intolerances
- ☐ Hives
- ☐ Frequent sneezing
- ☐ Severe reaction to insect bite