Patient Information Sheet

PLEASE PRINT LEGIBLY AND COMPLETE ALL INFORMATION Today's Date: ___________________________

Patient's Name: ____ Nickname (if any): ___________________________

Address: ____ City: ______________________ State: _____ Zip: _________

Phone (☑ **primary number**): ☐Home:(___)________________________ ☐Cell:(___)________________________

By providing your phone number, you consent to receive appointment reminders by our automated voicemail system. If not, please write "No Voicemail Reminders" at the top of this form.

Social Security No.: _________________________ Birthdate: _______________ Age: _______ Gender: Male / Female

Race: ☐ American Indian ☐ African-American ☐ Asian ☐ White ☐ Hispanic ☐ Native Hawaiian ☐ Other:____________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Language Spoken: ______________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Email address**: ____________________________________

Employer: ______________________________ Occupation: ______________________ Work Phone: (____)________________

Responsible party for this account (if different from patient): ___________________________ ___________________________
Name Address

_________________________ _________ _____________ (____)______________________ ______________________________
City State Zip Best Contact Phone DOB

Emergency Contact Person: __________________________________ _________________________ ____________________
Name Relationship to you Phone

Primary Insurance Company: __________________________________ Group/Policy Number ___________________________
Policyholder's Name: ____ Policyholder's DOB: __________________________
Policyholder's Social Security No:______________________________ ID# on Card: __________________________________
Relationship of the patient to the policyholder: SELF SPOUSE DEPENDENT

Secondary Insurance Company: _________________________________ Group/Policy Number ___________________________
Policyholder's Name: ____ Policyholder's DOB: __________________________
Policyholder's Social Security No:______________________________ ID# on Card: __________________________________
Relationship of the patient to the policyholder: SELF SPOUSE DEPENDENT

Is this a school/sports-related injury? ***Yes No*** If ***Yes***, Date of injury: ________________ School ________________________

Body part injured: ____

Is this a work-related injury? ***Yes No*** **If so, are you filing with Workers Comp?** ***Yes No***

Body part injured: ______________________________ Date of Injury: ____

WC Insurance: ________________________________ Adjustor: ____

Adjustor #: ___________________________________ Adjustor Fax: ____

Who is your primary physician? _____________________________ ***Who were you referred by?***______________________________

Pharmacy Preference: ____

Patient Privacy Notice (HIPPA Form)

This Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. Protected health information includes any information maintained by Cornerstone Sports Medicine that could identify you and your health condition.
You have the right to review our notice before signing this consent. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

Individuals who have your permission to access your protected health information are listed below:

_______________________________ Name _______________________________ Relationship

_______________________________ Name _______________________________ Relationship

By signing this form, you consent to our use and disclosure of your protected health information for treatment, payment, and healthcare operation. You have the right to revoke this consent, in writing, except where we have already made disclosure in reliance on your prior consent.

_______________________________ Signature of Patient (or Parent/Guardian°) _______________________________ Date

_______________________________ Patient Name - Printed _______________________________ Parent/Guardian Name - Printed

Authorization to Treat Minor

***If the patient is under 18 years of age, his/her parent or guardian must read and sign below**:

AUTHORIZATION TO TREAT MINOR

I hereby give permission to CORNERSTONE SPORTS MEDICINE and its staff to provide my daughter/son with evaluation (including x-rays) and treatment for his/her injuries.

_______________________________ **Signature of parent or legal guardian** _______________________________ **Date**

ASSIGNMENT OF BENEFITS

I hereby authorize Cornerstone Sports Medicine to furnish information to an insurance carrier concerning me and/or my dependent's illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to my dependents or myself. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account and/or my dependents for any professional services rendered. I understand that I am responsible for any amount not covered by insurance. I certify that the information I have provided to Cornerstone Sports Medicine is true and correct to the best of my knowledge and I will notify Cornerstone Sports Medicine of any changes. (A copy of this authorization shall be valid as the original.

Your receipt will provide all the necessary information for you to file with your insurance company if our office is not contracted with or filing to your insurance carrier.

_______________________________ Patient's Signature (or signature of parent/guardian for minor patients) _______________________________ Date

External Medication Consent Form

Patient medication history is a list of prescription medications that our practices providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important as it helps healthcare providers treat your symptoms and/or illness properly while avoiding potentially dangerous drug interactions.

Please make sure to discuss your medication list with your provider to ensure all medications are properly documented. Over the counter drugs and supplements may not be included in the external medication history. It is the patient's responsibility to provide information related to the medication list, including any added medication and any medications that have been discontinued. It is always best to keep a current list of medicines with you at each appointment. After reviewing your medication list with your provider, a copy of the list can be copied for your convenience. Please ask your provider or his assistant if you would like to obtain a copy at the end of your visit.

If a current medication list is not available, please contact my primary care physician for a current list.

PCP: ________________________________ PCP #: ___________________________

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

____ ___________________

Patient /Guardian Signature Date

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

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

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

Hand dominance: Right Left Height: ____________ **Weight:** ____________ **Pain Scale 0-10:** _______________

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)
Latex Allergy: YES / NO	

PAST MEDICAL HISTORY ***Please circle all that apply.***

Hypertension	HIV/AIDS	GERD	Irregular heart beat	Trigger finger
Diabetes	Lung Disease	Eye Disorder	Anemia	Cubital tunnel
Heart Disease	Sleep Apnea	Stomach Problems	Lupus	Tennis elbow
Pacemaker	Stroke	Depression	Scleroderma	De Quervain's
Arthritis	Seizures	Anxiety	Psoriasis	Amputation
Thyroid Disorder	Concussions	Liver Disease	Skin infections	Alzheimer's
Bleeding Disorder	Migraines	Carpal tunnel	MRSA/STAPH	Dementia
Headaches	Hepatitis	Kidney disease	Gout	ADD/ADHD

Have you ever had a heart attack or stroke? __________________ ***Are you diabetic?*** __________________________________

SURGERIES: *** Please include any HEART or ORTHOPEDIC 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

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

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

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

Social History Questionnaire

Patient Name ________________________________ Date of Visit ________________

Alcohol Assessment

1. **Did you have a drink containing alcohol in the past year?**
   - ☐ Yes
   - ☐ No

2. **If yes, how often do you have a drink containing alcohol?**
   - ☐ Monthly or less
   - ☐ 2-4 times a month
   - ☐ 2-3 times a week
   - ☐ 4 or more times a week

3. **If yes, how many drinks did you have on a typical day when you were drinking in the past year?**
   - ☐ 1 or 2
   - ☐ 3 or 4
   - ☐ 5 or 6
   - ☐ 7 or 8
   - ☐ 9 or more

4. **How often do you have six or more drinks on one occasion?**
   - ☐ Never
   - ☐ Less than monthly
   - ☐ Monthly
   - ☐ Weekly
   - ☐ Daily or almost daily

Smoking/Tobacco/Drug Assessment

1. **Do you currently use tobacco?**
   - ☐ Yes
   - ☐ No

   If yes, what type? _____________
   If yes, how frequently? _________

   Cigarettes per day: ____________

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

   If yes, when did you quit?
   _______ years/months ago

3. **Are you exposed to second hand smoke?**
   - ☐ Yes
   - ☐ No

4. **Do you use recreation drugs?**
   - ☐ Yes _____________________
   - ☐ No