# INSALL SCOTT KELLY

Today's Date:

## Patient Information

| | | | |
|---|---|---|---|
| Last Name: | First Name: | | MI: |
| Street Address: | | APT No: | |
| City: | | State: | ZIP Code: |
| Home Phone: | Work Phone: | | Cell Phone: |
| SSN: | DOB: | Gender: ⬭ Male ⬭ Female | Marital Status: ⬭ Single ⬭ Married ⬭ Divorced ⬭ Widowed |
| Race: | Ethnicity: | | Language: |

## Employment Information

| | | |
|---|---|---|
| Current employer: | Occupation: | |
| Employer address: | | Phone: |
| City: | State: | ZIP Code: |

## Emergency Contact

| | | |
|---|---|---|
| Name: | Relationship to Patient: | |
| Address: | | |
| City: | State: | ZIP Code: |
| Home Phone: | Work Phone: | Cell Phone: |

## Insurance Information

| | | |
|---|---|---|
| Primary Insurance: | Policy #: | Group #: |
| Name of Subscriber (if other than patient): | Subscriber DOB: | Patient's Relationship to Insured: ⬭ Self ⬭ Spouse ⬭ Divorced ⬭ Widowed |
| Primary Insurance Address: | | |
| City: | State: | ZIP Code: |
| Secondary Insurance: | Policy #: | Group #: |
| Name of Subscriber (if other than patient): | Subscriber DOB: | Patient's Relationship to Insured: ⬭ Self ⬭ Spouse ⬭ Divorced ⬭ Widowed |
| Secondary Insurance Address: | | |
| City: | State: | ZIP Code: |
| Work Related Injury ⬭ Yes ⬭ No If YES Describe: | | |
| Motor Vehicle Accident ⬭ Yes ⬭ No If YES Describe: | | |

## Referral Info

| | |
|---|---|
| Referring Physician's Name: | Phone: |
| Address: | |

## PCP Info

| | |
|---|---|
| Primary Care Physician's Name: | Phone: |
| Address: | |

## Pharmacy Information

| | | |
|---|---|---|
| Name of Pharmacy: | | Allergies: |
| Address: | Phone: | Fax: |
| City: | State: | ZIP Code: |

I hereby give my permission to the Insall Scott Kelly Institute for Orthopaedics and Sports Medicine to release medical information to insurance companies. I understand that charges incurred by me that are rendered by the physicians of the Insall Scott Kelly Institute for Orthopaedics and Sports Medicine and not covered by medical insurance are my responsibility.

| | |
|---|---|
| Signature: | Date: |

# INSALL SCOTT KELLY

Please fill out this form in its entirety. Please complete every line item, as it is necessitated by regulations from the government (Health Care Finance Administration – HCFA)

| | |
|---|---|
| **Patient Name:** | **Date:** |
| **Date of Birth:** | **Height: _____ Weight: _____** |
| **Who referred you?** | **What are you being seen for today?** |

*Note: if you are being referred by a doctor, please indicate doctor's full name, phone number and address in the box provided above.*

| | |
|---|---|
| **Which side is affected: O Right O Left O Bilateral** | **Date of Injury or start of pain:** |
| **How did the pain occur: O Injury O Chronic O Spontaneous** | **Quality of your pain? O Mild O Moderate O Severe** |
| **Type of Pain: O Sharp O Dull O Other:_____** | |

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| **Is this work related?** | — | — | **Is this the result of a motor vehicle accident?** | — | — |
| **Have you had physical therapy?** | — | — | **Have you been putting ice on the area?** | — | — |
| **Are you taking any pain medications?** | — | — | **Are you taking any anti-inflammatory agents?** | — | — |
| **Are you taking tylenol?** | — | — | **Are you taking any other medications** (if yes, please list on page 3)**?** | — | — |

**Have you had any testing such as the following? O X-Ray O MRI O EMG/NCS O Bone Scan O CT Scan**

## Social History:

| *Please answer the following questions.* | YES | NO | |
|---|---|---|---|
| **Have you ever had a blood transfusion?** | — | — | |
| **Do you participate in sports / recreational activities?** | — | — | **If yes, please list:** |

## Review of Systems:

| *Are you experiencing any of these issues now?* | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| **Fatigue?** | — | — | **Rashes / Sores?** | — | — |
| **Weight Change?** | — | — | **Skin Cancer?** | — | — |
| **Fever?** | — | — | **Itching / Burning?** | — | — |
| **Blood In Stool?** | — | — | **Nausea / Vomiting?** | — | — |
| **Diarrhea?** | — | — | **Stomach Ulcer?** | — | — |
| **Sexually Transmitted Diseases?** | — | — | | | |

## Family History:

*Do the below family members have any of the following?*

| | | | |
|---|---|---|---|
| **Mother:** | **O Cancer** | **O Osteoporosis** | **O Arthritis** |
| **Father:** | **O Cancer** | **O Osteoporosis** | **O Arthritis** |
| **Paternal Grandfather:** | **O Cancer** | **O Osteoporosis** | **O Arthritis** |
| **Paternal Grandmother:** | **O Cancer** | **O Osteoporosis** | **O Arthritis** |
| **Maternal Grandmother:** | **O Cancer** | **O Osteoporosis** | **O Arthritis** |
| **Maternal Grandfather:** | **O Cancer** | **O Osteoporosis** | **O Arthritis** |

## Allergies:

| | YES | NO | |
|---|---|---|---|
| **Are you allergic to any medications?** | — | — | **If yes, please list:** |
| **Are you allergic to food or environmental substances?** | — | — | **If yes, please list:** |

**Anything else you want to tell us about your visit today?**

Patient Signature: _____ Date: _____

# Patient Medical History

| **Patient Name:** | **DOB:** |
|---|---|
| **Primary Care Provider Dr:.**_____<br>**Ph:**_____ | **Cardiologist/Specialist Dr.:**_____<br>**Ph:** _____ |
| ***Diagnosis (office use only):***_____<br>***Surgical Procedure (office use only):*** _____ | ***Surgeon (office use only):***_____<br>***Ph (office use only):***_____ |
| **METS Score** (nurses use only): Wheelchair bound? Bedridden? | Height: Weight: |

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Do you have or are you being treated for high blood pressure? *If yes, how many years?*_____ | ☐ | ☐ | Have you ever had a heart valve replacement or repair? | ☐ | ☐ |
| Do you have chest pain with walking/normal activity? With exercise? | ☐ | ☐ | Do you have a pacemaker or defibrillator? | ☐ | ☐ |
| Have you ever had a coronary bypass or angioplasty? | ☐ | ☐ | Have you ever been told that you have a widening of your aorta or that you have an aortic aneurysm? | ☐ | ☐ |
| Have you ever had a heart attack?<br>*If yes, how many?:* _____*When?:* _____ | ☐ | ☐ | Have you ever been told you have peripheral vascular disease? | ☐ | ☐ |
| Do you have a heart stent?<br>*If yes, how many?:* _____ *When?:* _____ | ☐ | ☐ | Have you ever had a stress test?<br>*If yes, where?:* _____ *When?:* _____ | ☐ | ☐ |
| Do you have a weak or failing heart (congestive heart failure, CHF)? | ☐ | ☐ | Have you ever had a cardiac echo test?<br>*If yes, where?:* _____ *When?:* _____ | ☐ | ☐ |
| Do you have an irregular heartbeat or heart rhythm? | ☐ | ☐ | Have you ever had a heart catheterization?<br>*If yes, where?:* _____ *When?:* _____ | ☐ | ☐ |
| Do you have a heart murmur or mitral valve prolapse? | ☐ | ☐ | | | |
| Do you take daily medication for asthma? | ☐ | ☐ | Do you have difficulty breathing (do you wheeze)? | ☐ | ☐ |
| Do you have a history of chronic bronchitis or emphysema (COPD)? | ☐ | ☐ | Do you use supplemental oxygen? | ☐ | ☐ |
| Do you smoke? *If yes, how many packs / day:____ How may years have you been a smoker?:* _____ | ☐ | ☐ | Do you have a history of sleep apnea? CPAP? | ☐ | ☐ |
| Have you had any recent colds, fever or flu symptoms? | ☐ | ☐ | Have you ever been witnessed to stop breathing while asleep? | ☐ | ☐ |
| Do you have diabetes? *If yes, for how many years?:*_____*Complications?:*_____ | ☐ | ☐ | Do you take insulin? | ☐ | ☐ |
| Do you have kidney problems (other than kidney stones)? | ☐ | ☐ | Have you ever had Hepatitis A / B / C / D? (circle) | ☐ | ☐ |
| Do you have liver problems? | ☐ | ☐ | | | |
| Do you drink alcohol every day? *If yes, how many drinks/day:*_____ | ☐ | ☐ | Do you use recreational drugs? *If yes, specify*_____ | ☐ | ☐ |

# Patient Medical History

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Do you have a history of anemia? | ☐ | ☐ | Do you have a history of sickle cell disease or trait? | ☐ | ☐ |
| Do you take any blood thinners (e.g. Coumadin)? | ☐ | ☐ | Do you have a history of cancer? | ☐ | ☐ |
| Do you take Aspirin or Ibuprofen regularly? | ☐ | ☐ | Are you on Chemo Therapy? | ☐ | ☐ |
| Do you have seizures or take anti-seizure medications? | ☐ | ☐ | Do you have neuromuscular disease (including Parkinson's, ALS etc)? | ☐ | ☐ |
| Have you ever had a stroke(CVA), mini stroke(TIA) or brain attack? *If yes, when?:*_____ | ☐ | ☐ | Do you have a brain tumor, brain aneurysm or other vascular lesion of the brain? | ☐ | ☐ |
| Have you been told that it is difficult to place a breathing tube in your airway (intubate)? | ☐ | ☐ | Do you have a history of severe reaction to anesthesia? | ☐ | ☐ |
| Do you or a family member have a history of high fever after anesthesia (malignant hyperthermia)? | ☐ | ☐ | Do you suffer from chronic pain? | ☐ | ☐ |
| Do you have a history of severe nausea and vomiting after anesthesia? | ☐ | ☐ | Is there a possibility you could be pregnant? *LMP:*_____ | ☐ | ☐ |
| Do you have an autoimmune disease (such as Rheumatoid Arthritis, Sarcoidosis or Lupus)? | ☐ | ☐ | Do you have any other medical problems that we have not asked you about? *If yes, specify:*_____ | ☐ | ☐ |

*OFFICE USE: EKG results good for 6 months. Chemistry lab results good for 3 months*

Please list the medications you currently take and the dose.

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Patient Signature: _____ Date: _____

**Insall Scott Kelly Institute at St. Francis Hospital**
**Orthopaedics & Sports Medicine**

| PATIENT INFORMATION | |
|---|---|
| **Patient Name:** | **Date:** |
| **DOB:** | **Physician:** |

**Pharmacy Name**

**Pharmacy Address**

**Pharmacy Phone Number**

**St. Francis Hospital & Insall Scott Kelly Institute for Orthopaedics & Sports Medicine**

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the facility and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, sexually transmitted diseases, alcohol and substance abuse treatment information, mental health information, and genetic information.*

_____ _____

Signature of Patient or Personal Representative Print Name of Patient or Personal Representative

_____ _____

Description of Personal Representative's Authority Date

_____ _____

Signature of Facility Representative Date

## EXPRESS AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

*I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations. The St. Francis Hospital & Insall Scott Kelly Institute for Orthopaedics & Sports Medicine may need to disclose my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:*

*If I am unavailable, I expressly permit The St. Francis Hospital & Insall Scott Kelly Institute for Orthopaedics & Sports Medicine to disclose my protected health information for the purposes of appointment/test/procedure reminders and follow-up to the following individuals:*

_____ _____

(relationship to me)

_____ _____

(relationship to me)

*I expressly permit The St. Francis Hospital & Insall Scott Kelly Institute for Orthopaedics & Sports Medicine to disclose my protected health information for the purposes of appointment / test / procedure reminder and follow-up by leaving such information in the form of a message on the following recorded media:*

Home answering machine: Tel.# _____

Office voicemail: Tel.# _____

Other (specify): _____ Tel.# _____

_____ _____

Signature of Patient
Personal Representative
Parent/Guardian

Date

**St. Francis Hospital & Insall Scott Kelly Institute for Orthopaedics & Sports Medicine**

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_____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

_____ _____

Signature of Facility Representative Date

**Approved By:**

Dr. Patrick O'Shaughnessy, CMO
Lynn Jennings Taylor, SVP, Chief Privacy Officer

Date: _____, 2013