

PATIENT REGISTRATION THE SPORTS MEDICINE CLINIC

NEW PATIENT
 UPDATE

PLEASE PRINT PATIENT'S NAME

Acct # _____

Last:	First:	MI:
Address:		
City:	State:	Zip:
Home Phone:		
Work Phone:		
Cell Phone:		
Employer or School:		
Occupation:		
Social Security #:		
Birthdate:		
Sex:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Marital Status:	Single <input type="checkbox"/>	Married <input type="checkbox"/> Widowed <input type="checkbox"/>
Other:		

Person Responsible for Bill:

Name:		
Address:		
City:	State:	Zip:
Home Phone:		
Work Phone:		
Cell Phone:		

EMERGENCY CONTACT: *Nearest friend or relative not living with you*

1) Name	
Phone	
2) Name	
Phone	

PRIMARY INSURANCE	
Insurance Company:	
Group #:	Local #:
Policy Holder's Name:	
Policy Holder's SS #:	
Policy Holder's Birthdate:	
Insurance Co. Address:	
City:	State: Zip:
Insurance Co. Phone #:	

PCP _____ Co-pay _____

Patient's Relationship to Insured
 Self Spouse Child Other _____

SECONDARY INSURANCE	
Insurance Company:	
Group #:	Local #:
Policy Holder's Name:	
Policy Holder's SS #:	
Policy Holder's Birthdate:	
Insurance Co. Address:	
City:	State: Zip:
Insurance Co. Phone #:	

Patient's Relationship to Insured
 Self Spouse Child Other _____

If you are being seen because of an **AUTO ACCIDENT** or an **INJURY THAT OCCURRED AT WORK**, PLEASE complete the following:

WORK INJURY	
Date of Accident:	
Employer at the Time of injury:	
Insurance Co.:	
Claim #:	
Insurance Co. Address:	
City:	State: Zip:
Insurance Co. Phone #:	

Date of Injury/Symptom: _____

Cause of Injury: _____

Have you been treated by a physician for this problem: Yes No

If yes, name(s) of physician: _____

How did you hear about our clinic? _____

CAR ACCIDENT	
Date of Accident:	
Employer at the Time of injury:	
Insurance Co.:	
Claim #:	
Insurance Co. Address:	
City:	State: Zip:
Insurance Co. Phone #:	

Body part involved _____ Left Right

ASSIGNMENT AND RELEASE: I authorize my insurance company to pay directly to **The Sports Medicine Clinic** for my treatment. I also authorize the release of any medical information necessary to process these claims. I understand that, regardless of insurance coverage, I am responsible for the balance of my account. The above information is complete and accurate to the best of my knowledge.

I ACKNOWLEDGE RECEIPT OF A NOTICE OF PRIVACY PRACTICES, DESCRIBING HOW MY HEALTH INFORMATION MAY BE USED AND DISCLOSED.

SIGNATURE: _____ DATE: _____

THE SPORTS MEDICINE CLINIC
PATIENT HEALTH QUESTIONNAIRE

Patient Name _____
(please print)
Today's Date _____
Patient Signature _____

MEDICAL HISTORY

What is your height? _____ **What is your weight?** _____ **Your Age?** _____

Have you had any Serious Injuries / Illnesses / Medical Problems? _____ **Date:** _____

Have you been Hospitalized or had Surgery? _____ **Date:** _____

Medications/Vitamins _____

Known Allergies to Medicine (please list) _____

Immunizations: (last date of) Flu _____ Tetanus _____ Pneumovax _____

FOR WOMEN ONLY:

of pregnancies _____ #of miscarriages _____ #of abortions _____ Age at 1st menstrual cycle? _____
Age at menopause _____ Date of last pap smear _____ Date of last mammogram _____

PATIENT SOCIAL HISTORY

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Current Occupation: _____

Use of Alcohol: Never _____ Rarely _____ Moderate _____ Daily _____

Use of Caffeine, Cups per Day: Coffee _____ Sodas _____ Tea _____

Use of Tobacco: Never _____ Previously, but quit _____ Current pack/day _____

Use of Drugs: Never _____ Type/Frequency _____

Exercise: Never _____ Rarely _____ Weekly _____ Daily _____ Type of Exercise: _____

DO YOU HAVE A "Living will"? Yes _____ No _____

Would you like more information about Health Care Directives and Durable Power of Attorney? Yes _____ No _____

FAMILY MEDICAL HISTORY

Do you know of any blood relative who has or had: (indicate relationship)

Arthritis	_____	High Blood Pressure	_____
Asthma/Allergies	_____	Mental Illness	_____
Bleeding Tendency	_____	Reaction to Anesthesia	_____
Cancer	_____	Stroke	_____
Diabetes	_____	TB	_____
Genetic Disorder	_____	DVT, Blood Clot or	_____
Heart Disease	_____	Pulmonary Embolism	_____

ARE YOU EXPERIENCING OR HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING:

CONSTITUTIONAL SYMPTOMS

Unexplained weight gain or loss..... yes no
 Fever or chills..... yes no
 Night sweats/Hot flashes..... yes no
 Fatigue yes no

HEMATOLOGIC/LYMPHATIC

Bleeding or bruising tendency..... yes no
 Anemia yes no

EYES

Blurred or double vision..... yes no

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing yes no
 Earaches or drainage..... yes no
 Chronic sinus problem or rhinitis..... yes no
 Recurrent nose bleeds yes no
 Bleeding gums..... yes no
 Sore throat or voice change (hoarseness) yes no
 Hay fever yes no

CARDIOVASCULAR

Heart trouble..... yes no
 Chest pain or angina pectoris..... yes no
 Palpitation (fast or irregular heart beat)..... yes no
 Shortness of breath while walking or lying flat .. yes no
 Swelling of feet, ankles or hands..... yes no
 High blood pressure yes no
 DVT, blood clot or pulmonary embolism..... yes no
 Have you ever been on IV antibiotics?..... yes no

RESPIRATORY

Chronic or frequent coughs yes no
 Spitting up blood..... yes no
 Shortness of breath yes no
 Asthma or wheezing..... yes no

GASTROINTESTINAL

Loss of appetite..... yes no
 Change in bowel movement..... yes no
 Nausea or vomiting yes no
 Frequent Diarrhea yes no
 Painful bowel movement or constipation..... yes no
 Rectal bleeding or blood in stool yes no
 Abdominal pain or heartburn..... yes no
 Peptic ulcer (stomach or duodenal)..... yes no
 Trouble swallowing yes no

GENITOURINARY

Frequent urination yes no
 Burning or painful urination yes no
 Blood in urine yes no
 Urination at night (> 1/night)? yes no
 Incontinence or dribbling yes no
 Decrease in urine stream yes no
 Kidney stones..... yes no
 Sexual difficulty yes no
 Slow to start/stop urination yes no
 Female - pain with periods yes no
 Female - irregular periods yes no
 Female - Contraception type _____
 Female - Days in menstrual cycle _____
 Female - Date of last menstrual period _____

MUSCULOSKELETAL

Joint pain yes no
 Joint stiffness or swelling..... yes no
 Back pain..... yes no

INTEGUMENTARY (skin, breast)

Rash or itching yes no
 Breast pain yes no
 Breast lump yes no
 Breast discharge yes no

NEUROLOGICAL

Frequent or recurring headaches yes no
 Light headed or dizzy yes no
 Convulsions or seizures yes no
 Numbness or tingling sensations yes no
 Paralysis..... yes no
 Memory loss or confusion yes no

ENDOCRINE

Thyroid disease yes no
 Diabetes yes no
 Other glandular or hormone problem yes no

OTHER

Nervousness yes no
 Depression/Anxiety/Panic yes no
 Insomnia..... yes no
 MRSA Infection..... yes no

Other concerns not noted above:

Physician Initials: _____

Date: _____