Name: _____
Chart: _____
Date: _____
Provider: _____
Appt Time: _____

Demographics:

Name: _____ Name to be called _____

Sex: _____ DOB: _____

Primary Phone: _____ ☐ Home ☐ Work ☐ Cell

Alternate Phone: _____ ☐ Home ☐ Work ☐ Cell

EMAIL: _____ **To be used for office communication

Patient Employer: _____ Occupation: _____

Name of Spouse: _____ Contact Phone Number: _____

Emergency Contact: _____ Contact Phone Number: _____
(Outside of Home) Name Relationship

Current School: _____ Grade _____

Sport(s)/position: _____

Injury/Symptom History:

Is this an injury/condition we are currently (in the last 6 months) treating you for? ☐ Yes (skip to next section)

☐ No, it's a new complaint Date Injury Occurred/Onset of Symptoms: Month_____ Day____ Year _____

Body Part: _____ ☐ Right ☐ Left

How did Injury/Accident/Symptoms occur: _____

Current Treatment: ☐ Heat ☐ Ice ☐ Elevation ☐ Rest ☐ NSAIDs ☐ Other: _____

MRI/XRAY/Imaging: When?: _____ Where?: _____

Surgery: When?: _____ What Doctor?: _____

Other: _____

Is this a Workman's Compensation case? ☐ Yes ☐ No

Adjuster: _____ Phone: _____

IF 19 YEARS OLD OR YOUNGER, PLEASE PROVIDE THE FOLLOWING INFORMATION

Guardian's Name: _____ Last 4 SSN _____

Primary Contact number: _____ Alternate Contact Number: _____

____ Patient lives with this guardian ____ This Guardian is responsible for making medical decisions

Guardian's Name: _____ Last 4 SSN _____

Primary Contact number: _____ Alternate Contact Number: _____

____ Patient lives with this guardian ____ This Guardian is responsible for making medical decisions

Andrews Sports Medicine Medical History

Patient Name: _____ Chart: _____
Primary Phone: _____ Date: _____
Pharmacy _____ Phone: _____ Zip _____ Location: _____
Primary Care M.D. _____ Phone: _____ Fax: _____
Cardiologist _____ Phone: _____ Fax: _____

MEDICAL HISTORY *(check all that apply)* ☐ **I HAVE NO KNOWN MEDICAL PROBLEMS**

☐ Heart Disease	☐ Seizures	☐ MRSA	☐ Diabetes; Type ___	☐ Kidney Disease
☐ Atrial Fibrillation	☐ COPD/Emphysema	☐ Cancer	☐ Thyroid Disorder	☐ Liver Disease
☐ High Blood Pressure	☐ Asthma	☐ Ulcer	☐ Rheumatoid Arthritis	☐ Hepatitis;Type___
☐ Prior Blood Clot	☐ Sleep Apnea	☐ Reflux	☐ Fibromyalgia	☐ HIV/AIDS
☐ Stroke/TIA	☐ Tuberculosis	☐ Menopause	☐ Gout/Pseudogout	☐ Depression/Anxiety

☐ Other: _____

CURRENT MEDICATIONS: *(please list **ALL** current medications along with **dose & frequency**. Include aspirin & supplements)*

Select if using: ☐ Pain Medication ☐ Blood thinner ☐ Chemotherapy ☐ Birth Control ☐ Chronic Steroids

Currently under Pain Management? ☐ No ☐ Yes Doctor _____ Condition _____

ALLERGIES: ☐ None ☐ Latex ☐ Eggs/Chicken ☐ Nickel ☐ Penicillin
☐ Medications (describe reaction) _____

PRIOR SURGERY *(include ALL)* ☐ Pacemaker ☐ Defibrillator ☐ Cardiac Stent(s)

Will you accept blood transfusion if necessary? ☐ Yes ☐ No **Any prior complications with anesthesia?** ☐ Yes ☐ No
Do you have a personal or family history of Malignant Hyperthermia? ☐ Yes ☐ No

FAMILY HISTORY:	Parent	Sibling
Arthritis		
Diabetes		
Heart Disease		
Clotting Disorder		
Osteoporosis		
Unknown Family History		

SOCIAL HISTORY *(check appropriate box and fill in blanks)*

Marital Staus	**Alcohol**	**Tobacco**	**Drug Use**
☐ Single	☐ None	☐ Never ☐ Smokeless	☐ Never ☐ Prior
☐ Married	☐ Rarely	☐ Former; Stopped _____	☐ Current IV Use
☐ Divorced	☐ Weekly	☐ Current	☐ Other
☐ Widowed	☐ Daily	# packs per day _____	**Hand Dominance**
☐ Other	# drinks____	# years smoked _____	☐ Right ☐ Left

Occupation/School/Sports/Hobbies: _____

REVIEW OF SYSTEMS *(please circle yes or no)*

HEIGHT: _____ **WEIGHT:** _____

General		**Cardiovascular**		**Gastrointestinal**		**Skin**	
Weight Gain/Loss	Yes/No	Chest Pain	Yes/No	Nausea/Vomiting	Yes/No	Rash/Itching	Yes/No
Fever/Chills	Yes/No	Palpitations	Yes/No	Diarrhea	Yes/No	**Neurological**	
Night Sweats	Yes/No	Heart Murmur	Yes/No	**Endocrine**		Numbness	Yes/No
Fatigue	Yes/No	**Respiratory**		Increased Thirst	Yes/No	Weakness	Yes/No
Dizziness	Yes/No	Cough/Sputum	Yes/No	Excessive Hunger	Yes/No	Tremor/Shaking	Yes/No
Ear-Eyes-Nose-Throat		Difficulty Breathing	Yes/No	**Genitourinary**		**Psychological**	
Vision Change	Yes/No	**Musculoskeletal**		Urinary Infections	Yes/No	Depression	Yes/No
Ringing in Ears	Yes/No	Joint Pain	Yes/No	Incontinence	Yes/No	Panic attacks	Yes/No
Nose Bleeds	Yes/No	Backache	Yes/No	Dialysis	Yes/No	Mood Swings	Yes/No
Hard to Swallow	Yes/No	Muscle Pain	Yes/No				

Patient Signature *(if over 14 y/o)* **Date**

Provider Signature (reviewed) **Date**

Name: _____

Chart: _____

Date: _____

ANDREWS

Sports Medicine & Orthopaedic Center

Workers' Compensation or Legal Referral

Referral Source: _____

Occupation: _____

Employer: _____

How long employed? _____ Date of Injury/Symptoms: _____

Are you presently working at same employer? ☐ Yes ☐ No

If employed but not working, date last worked: _____

If fired or terminated, please give date: _____

If working: ☐ Full Duty ☐ Restricted (limited) duty

Describe injury/symptoms: _____

_____

_____

_____

Symptoms are... ☐ constant ☐ intermittent or occasional

Symptoms are... ☐ improving ☐ unchanged ☐ worsening

Pain Rating:	No Pain	0	1	2	3	4	5	6	7	8	9	10 Worst pain
Rate pain at *its* worst		0	1	2	3	4	5	6	7	8	9	10 Worst pain
Rate pain at its best (or at least)		0	1	2	3	4	5	6	7	8	9	10

List activities or things that worsen symptoms: _____

_____

List things that improve symptoms: _____

_____

Please circle tests you have had for this problem and give date:

MRI _____ CT Scan _____

Bone Scan _____ EMG/NCV (nerve test) _____

Treatments for this problem (please note if helped):

				Helped?		
Medications:	☐ Yes ☐ No	Names	_____	☐ none	☐ some	☐ a lot
Therapy:	☐ Yes ☐ No	How long/where?	_____	☐ none	☐ some	☐ a lot
Braces/splints:	☐ Yes ☐ No	Describe:	_____	☐ none	☐ some	☐ a lot
Injections:	☐ Yes ☐ No	Location	_____	☐ none	☐ some	☐ a lot

Previous problems or surgeries with this part of the body before? If so, please describe.

_____

_____

Legal Representation? ☐ Yes ☐ No

Previous Worker's Compensation Injuries? ☐ Yes ☐ No

If yes, did it involve the same area as now? ☐ Yes ☐ No

If yes, please describe the problem and treatment. _____

_____

Name: _____

Chart: _____

Date: _____

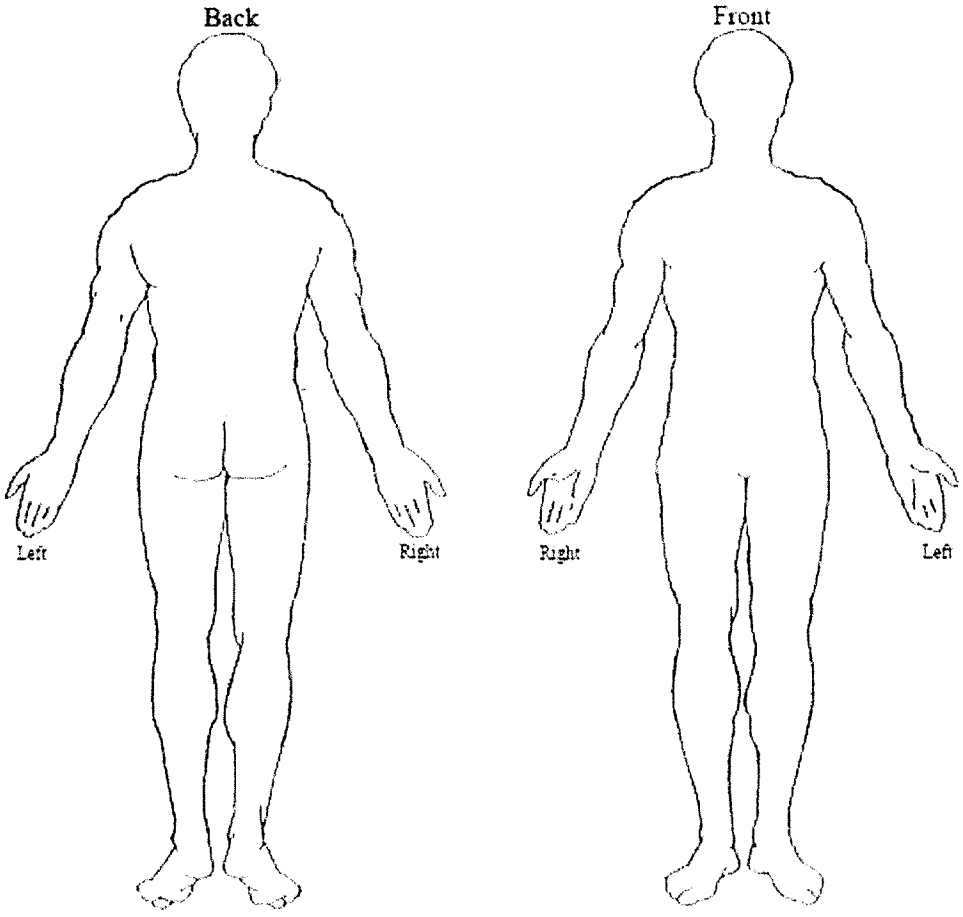
PAIN DRAWING

NAME: _____ DATE: _____

Where is your pain now?

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas. Just to complete the picture, please draw in your face.

Aching	Numbness	Pins and needles	Burning	Stabbing	Other
L L L	= = = =	0 0 0	x x x x	/ / /	♦ ♦ ♦



FC14

Name: _____

Chart: _____

Date: _____

Andrews Sports Medicine

805 St. Vincent's Drive • Suite 100 • Birmingham, Alabama 35205

Authorization for Medical Treatment: The undersigned has been informed of the treatment procedures considered necessary for the patient and that the treatment/procedures will be directed by a physician and performed by employees of Andrews Sports Medicine and Orthopaedic Center. The undersigned understands that no guarantee or assurance has been made as to the results that may be obtained from treatment. Authorization is hereby granted for treatment.

Information Privacy: Andrews Sports Medicine and Orthopaedic Center will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. The undersigned acknowledges receipt of this information and has refused to retain a copy.

Release of Information: Andrews Sports Medicine and Orthopaedic Center is hereby authorized to disclose all or part of my information regarding medical condition, treatment and prognosis to insurance carriers, other treating physicians, trainers, rehabilitation nurses, orthopaedic technicians and/or coaches. I agree that Andrews Sports Medicine and Orthopaedic Center may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes. I also authorize Andrews Sports Medicine and Orthopaedic Center to utilize medical information obtained during the course of my treatment in medical research and education programs, provided my name and likeness are not revealed and my privacy is completely protected.

Assignment of Insurance Benefits: In the event the undersigned is entitled to benefits of any kind whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to Andrews Sports Medicine and Orthopaedic Center for application on the patient's bill. The undersigned, and/or patient agrees to be responsible for charges not covered by the assignment, including deductibles and co-payments prescribed by law.

Financial Agreement: The undersigned agrees that in consideration for the services to be rendered to the patient, he/she individually agrees to be totally responsible for all charges for services such as, **DURABLE MEDICAL SUPPLIES, SYNVISC, SUPARTZ, SYNVISC ONE,** and any other non-covered charges. The undersigned agrees to assign payment for the unpaid charges from services provided by specialist and by physicians for whom Andrews Sports Medicine and Orthopaedic Center is authorized to bill. I, the undersigned, accept the fee(s) charged as a legal and lawful debt. I understand the fee(s) charged are due at the time of service. Should it become necessary to forward my account for collection, I agree to pay all monies due, including a 33% collection fee, attorney fees, and/or court costs, if such be necessary. I waive now and forever, my right of exemption under the laws of the Constitution of the State of Alabama and any other state. All delinquent balances shall bear interest at the legal rate. Complete payment policies can be found at www.andrewscenters.com .

Medicare Authorization: I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits. either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible in paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Surgical Consent: I understand that my surgery may overlap with another procedure my doctor is scheduled to perform. I understand that this means my surgeon will be present in the operating room during the critical parts of my surgery, but may not be present for my entire surgery. The physician may supervise a surgical team which could include another attending surgeon, a surgery fellow, surgery resident or a physician's assistant. Qualified members of this team may perform parts of the surgery. I understand that my surgeon or another credentialed surgeon will be immediately available should the need arise during my surgery. Upon scheduling a surgery, I will be given an opportunity to ask any questions or voice concerns about this or my procedure.

Miscellaneous Provisions: I consent to receive calls and/or text messages regarding my healthcare information and other healthcare-related services at the phone number(s) given. I understand I may be charged for calls to my wireless phone by my wireless carrier, and that calls may be generated by a I automated dialing system. I further understand that I may revoke this consent at any time by notifying my healthcare provider in writing. I understand that under no circumstances will Andrews Sports Medicine and Orthopaedic Center be liable for property of patients.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE, AND ACCEPTS THE TERMS THEREOF.

"Andrews Sports Medicine and Orthopaedic Center complies with applicable Federal Civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex".

Patient's Signature _____ Date: _____
if over 14 years of age

Parent / Responsible party _____ Date: _____
Please Print

Parent / Responsible party _____ _____
Signature *RELATIONSHIP*