Name: _____

DOB: _____

ADVANCED
Center for Orthopedics & Sports Medicine
FOCUSED ON YOU

SECTION 1
Patient Information – Information About the Person Who Is Being Treated

Patient Last Name		Patient First Name (Legal Name)		Patient Middle Name
Name That You Prefer to Be Called	Age	Date of Birth	Social Security Number	Gender
Marital Status ☐Single ☐Married ☐Divorced ☐Widowed		Email Address (Your email will only be used to communicate with you about your care, account, service surveys, or education.)		
Mailing Address (Include Apartment/Suite #)		City	ST	Zip
Patient Home Phone Number (If Applicable)		Patient Cell Phone Number (If Applicable)		Patient Work Telephone Number (If Applicable)

In the event that we need to contact you to reschedule an appointment, ask you a question related to your care, etc., please indicate which number above is the best number to reach you: ☐Home ☐Cell ☐Work What is the next best number to reach you? ☐Home ☐Cell ☐Work

Patient Employer (If Applicable)	Employer Phone (If Applicable)	Family/Primary Care Doctor (If Applicable)
Emergency Contact Name	Emergency Contact Phone	Emergency Contact Relationship ☐Spouse ☐Child ☐Parent ☐Brother/Sister ☐Other
Is the patient currently residing in a skilled medical nursing facility? ☐No ☐Yes	If Yes, please provide the facility name and address.	

SECTION 2
In compliance with Advanced Center for Orthopedics & Sports Medicine's participation in a government program on patient quality of care, we ask that you provide the following information.
(Please note that you have the option to decline to answer these questions.)

Preferred Language: ☐English ☐Spanish ☐Other, Please List: _____

Race: ☐African American ☐American Indian ☐Asian ☐Caucasian ☐Native Hawaiian ☐Unknown

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unknown

SECTION 3
Spouse Information (If Applicable)

Spouse Last Name	Spouse First Name (Legal Name)	Spouse M.I.	Spouse SS#
Spouse Employer (If Applicable)	Spouse Employer's Phone (If Applicable)		Spouse Date of Birth

SECTION 4
Insurance Information (If Applicable)

Primary Insurance Name (i.e., Humana, Medicare, etc.)	Name of Policy Owner (Last Name, First Name)	Policy Owner Date of Birth
Secondary Insurance Name (i.e., Humana, Medicare, etc.)	Name of Policy Owner (Last Name, First Name)	Policy Owner Date of Birth
Other Insurance Name (i.e., Humana, Medicare, etc.)	Name of Policy Owner (Last Name, First Name)	Policy Owner Date of Birth

If your visit is due to an injury at work or occurred during an auto accident, at home, at school/a school activity, or at any other place, you may be required to provide additional information.

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Name: _____

DOB: _____

ADVANCED Center for Orthopedics & Sports Medicine

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SECTION 5

If the patient is a MINOR, please complete this section.

Mother/Female Guardian Information		Father/Male Guardian Information	
Mother/Female Guardian Name (Last Name, First Name – Legal Names)		Father/Male Guardian Name (Last Name, First Name – Legal Names)	
Mother/Female Guardian Address (Complete Only if Different From Above)		Father/Male Guardian Address (Complete Only if Different From Above)	
Best Telephone Number to Reach Mother/Female Guardian	Mother/Female Guardian Date of Birth	Best Telephone Number to Reach Father/Male Guardian	Father/Male Guardian Date of Birth
Mother/Female Guardian Employer (If Applicable)	Employer Telephone	Father/Male Guardian Employer (If Applicable)	Employer Telephone

CONSENT FOR MEDICAL TREATMENT

I, for myself, or the patient named above, hereby consent to such medical evaluation and/or treatment and diagnostic procedures as necessary and appropriate for my condition or illness based on the judgment of my physician(s), to be performed by the physician(s), physician assistant(s), nurse practitioner(s), nurse(s), and other healthcare provider(s). I have had, and will continue to have, an opportunity to discuss treatment options with my healthcare provider, ask questions regarding such treatment options, and understand the options discussed.

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I understand that I have rights regarding my protected health information (PHI). These rights are governed by the Health Insurance Portability and Accountability Act (HIPAA). I have been informed and given the opportunity to review and secure a copy of the clinic's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my PHI.

I hereby authorize the release and disclosure of my PHI for treatment, payment, or healthcare operations. I understand that any and all records concerning my personal and medical history are confidential property of Advanced Center for Orthopedics & Sports Medicine.

I agree that Advanced Center for Orthopedics & Sports Medicine may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

CONSENT FOR FINANCIAL RESPONSIBILITY

I acknowledge full financial responsibility for services rendered by Advanced Center for Orthopedics & Sports Medicine. I authorize direct payment of my insurance benefits to my or my dependent's provider(s). I agree to pay the remainder of the balance not paid by my insurance company and any applicable service charges on past due balances. If any collection action is necessary, I agree to pay reasonable attorney's fees to/for any attorney who is not an employee of Advanced Center for Orthopedics & Sports Medicine.

CONTACT AUTHORIZATION

I give authorization to the doctors and staff of Advanced Center for Orthopedics & Sports Medicine to discuss my medical and/or financial information with the following people. I understand that it is my responsibility to inform Advanced Center for Orthopedics & Sports Medicine of any desired changes in this authorization.

Name:	Relationship:	Name:	Relationship:

X _____ _____ _____

Signature of Patient or Responsible Party | Printed Name of Patient or Responsible Party | Date

BC2

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Name: _____

DOB: _____

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The following information helps us with your office visit today.

If you've been injured, what was the date of the injury? _____

Where did the injury occur? (Please ✓ one.)

☐Home ☐Work ☐School ☐Other: _____

If the injury or symptoms are related to work, please inform our receptionist. (Additional paperwork may be required.)

If not an injury, on what date did the symptoms begin?_____

Location of the injury or symptoms (such as the knee, hip, etc.): _____

Is this on the ☐Left or ☐Right (Please ✓ one.)

If an injury, please describe how it occurred:

_____

_____

_____

If not an injury, please describe the symptoms:

_____

_____

_____

Signature:_____Today's Date: _____

BC11

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Name: _____

DOB: _____

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PATIENT'S HEALTH HISTORY

	Yes	No
Stroke		
Heart Trouble		
High Blood Pressure		
Lung Diseases		
Tuberculosis		
Diabetes		
Bleeding Disorders		
Phlebitis/ Blood Clots		
Anemia		
Arthritis		
Gout		
Seizures		
Mental Illness		
Alcoholism		
Cancer		
Kidney Trouble or Stones		
Stomach Ulcers		
Liver Trouble		
Thyroid Trouble		
Serious Injuries		
Other Illnesses		
Fractures		

Surgical Procedures
(Include Approximate Dates)

_____

_____

_____

_____

Allergies to Medicines ☐ None

_____

_____

_____

_____

Are You:
☐ Right-Handed
☐ Left-Handed

FAMILY HISTORY

	Yes	No
Bleeding Disorders		
Anesthesia Problems		
Stroke		
Heart Trouble		
Diabetes		
High Blood Pressure		
Arthritis		
Gout		
Seizures		
Mental Illness		
Kidney Trouble		
Cancer		
Alcoholism		
Other		

SOCIAL HISTORY

Family Physician:

_____

Sex: ☐ Male ☐ Female

Race: _____

Currently Employed: ☐ Yes ☐ No

If Yes, Current Occupation:

_____

Retired: ☐ Yes ☐ No

☐ Married ☐ Single ☐ Divorced

Currently Living Alone ☐ Yes ☐ No

Smoke_____Packs Per Day

Alcohol Consumption:
☐ Never ☐ Occasional
☐ Moderate to Heavy

Drug Overuse:
☐ None ☐ Presently
☐ Past Problem

Have You Ever Tested POSITIVE for:
☐ HIV ☐ Hepatitis

REVIEW OF SYSTEMS

Have You Recently Had or Do You Now Have:

	Yes	No
Reading Glasses		
Difficulty Swallowing		
Loss of Hearing		
Nose Bleeds		
Change of Vision		
Shortness of Breath		
Heart or Chest Pain		
Hoarseness		
Morning Cough		
Chills or Fever		
Abnormal Heartbeat		
Badly Swollen Ankles		
Calf Cramps With Walking		
Poor Appetite		
Toothache		
Gum Trouble		
Nausea or Vomiting		
Stomach Pain		
Ulcers		
Hemorrhoids		
Frequent Loose Bowel Movements		
Blood in Bowel Movements		
Frequent Constipation		
Frequent Urination (Pass Water)		
Difficulty Starting Urination		
Difficulty Stopping Urination		
Get Up Every Night to Urinate		
Frequent Headaches		
Blackouts		
Seizures		
Frequent Rashes		
Hot or Cold Spells		
Recent Weight Change		
Nervous Exhaustion		
Insomnia		
Depression		
Nervous Tension		
Women: Irregular Periods		

Signature: _____ ***Date:*** _____

BC12

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Name: _____

DOB: _____

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Center for Orthopedics & Sports Medicine
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I agree that Advanced Center for Orthopedics & Sports Medicine may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

_____ _____

Patient Signature Date

Pharmacy Information					
☐	IGA Hometown	Rockport	☐	Rice Drugs	Beaver Dam
☐	Clinic South	Beechmont	☐	Rice Drugs	Fordsville
☐	Central City Clinic Pharmacy	Central City	☐	Ridgeview	OWENSBORO – New Hartford
☐	CVS	OWENSBORO – Frederica	☐	Rite Aid	Calhoun
☐	CVS	OWENSBORO – Hwy 54	☐	Rite Aid	Greenville
☐	CVS	Tell City	☐	Rite Aid	Henderson – 2nd St.
☐	Danhauer	OWENSBORO – Frederica	☐	Rite Aid	Henderson – 5th St./Green St.
☐	Pharmacy Plus/Don & Daisy	OWENSBORO – Byers	☐	Rite Aid	Leitchfield
☐	Emory	OWENSBORO – Emory Dr.	☐	Rite Aid	Madisonville
☐	Fred's	Hartford	☐	Rite Aid	OWENSBORO – Hwy 60
☐	Fred's	Lewisport	☐	Rite Aid	OWENSBORO – New Hartford
☐	Greenville Pharmacy	Greenville	☐	Rite Aid	OWENSBORO – Parrish Ave.
☐	King's	OWENSBORO – Carter Rd.	☐	Rite Aid	OWENSBORO – Scherm Rd.
☐	King's	Hartford	☐	Rockport Pharmacy	Rockport
☐	King's	Powderly	☐	Spinks	Hartford
☐	Kroger	Madisonville	☐	Target	OWENSBORO – Frederica
☐	Kroger	OWENSBORO – Hwy 60	☐	Taylors	Hardinsburg
☐	Kroger	OWENSBORO – Starlite/Parrish	☐	Town & Country	Hardinsburg
☐	Kroger	OWENSBORO – Wesleyan Park	☐	Walgreen's	Madisonville
☐	Lincoln	OWENSBORO – Veach Rd	☐	Walgreen's	OWENSBORO – Frederica
☐	Madisonville Pharmacy	Madisonville	☐	Walgreen's	OWENSBORO – Hwy 54
☐	Medical Center	Powderly	☐	Wal-Mart	OWENSBORO – Frederica
☐	Nation's	OWENSBORO – Burlew	☐	Wal-Mart	OWENSBORO – Hwy 54
☐	Nation's	OWENSBORO – Carter Rd.	☐	Wal-Mart	Central City
☐	Nation's	OWENSBORO – Hwy 54	☐	Wal-Mart	Beaver Dam
☐	Poole's	Central City	☐	Wal-Mart	Henderson
☐	Poole's	Livermore	☐	Wal-Mart	Tell City
☐	Poole's	OWENSBORO – Hwy 54	☐	Whitesville Drug	Whitesville
			☐	Commonwealth Family	OWENSBORO
☐	Other				

BC8

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Name: _____

DOB: _____

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CURRENT MEDICATION

ALLERGIES _____

Prescription and Over the Counter					
Medication	Dosage	Date	Date Discontinued	Restart Date	Initial/Date

Patient Signature: _____

BC7

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