

Lubbock Sports Medicine

Patient Registration

PATIENT INFORMATION (Please Print) E-MAIL ADDRESS _____

Check One: Male Female

Patients Last Name	First Name	Middle Name	Date of Birth	Age	Marital Status	Social Security No.
Mailing Address		City	State	Zip	Home Phone	
Patient's Employer or School Attending			Occupation		Business Phone	
Employer's Address		City	State	Zip	Cell Phone	

(If Minor/Student Please Provide the Information in this Section)

Parent's Last Name	First Name	Middle Name	Home Phone		
Mailing Address		City	State	Zip	Cell Phone

EMERGENCY CONTACT (FRIEND, NEIGHBOR, NEAREST RELATIVE NOT LIVING WITH YOU)

Name	Address	City	State	Zip	Home/Cell Phone
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WHO REFERRED YOU TO THIS PRACTICE? (PLEASE CHECK)

Physician
 Patient
 Trainer/Coach
 Yellow Pages
 Friend
 Website
 Commercial
 Other _____

Name: _____ Phone: _____

FAMILY PHYSICIAN:

Name	Address	City	State	Zip	Phone
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REASON FOR VISIT: Specify Problem (EX-Left Knee got hit and twisted) INCLUDE DATE & TIME OF INJURY

Date & Time of Injury or First Symptom(s)
If an injury, where did it occur? (PLEASE CHECK ONE): <input type="checkbox"/> Home <input type="checkbox"/> Liability <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Job <input type="checkbox"/> Sport, type _____

INSURANCE INFORMATION (COMPLETE ONLY IF YOU ARE NOT THE POLICY HOLDER)

Insurance Company Name					
Policy Holder's Name	Mailing Address	City	State	Zip	Home Phone
Policy Holder's Employer	Employer's Address	City	State	Zip	Business Phone
Policy Holder's SS#	Date of Birth	Policy Holder's Spouse Name		Cell Phone	
Other Insurance Name			(If policy holder is different than above-please fill out below)		
Policy Holder's Name	SS#	Date of Birth			
Mailing Address		City	State	Zip	

Patient or Authorized Person's Signature: _____ Date: _____

PATIENT HISTORY

Please PRINT and fill out completely

Name: _____ Nickname: _____ Today's Date: _____

Age: _____ Height: _____ Weight: _____ What Body part is injured: _____ Right Left
Hand Dominance: Right Left

HISTORY OF INJURY

Is the injury **CHRONIC**? Yes No If **YES**, how long has it been going on for? _____

Is the injury **NEW** as a result of a specific injury? Yes No If **YES**, date of injury/accident: (full date) _____

Describe in your own words how the initial injury occurred and how it limits your current level of activity:

Did your problems begin following: Work injury Motor Vehicle Accident Accident Other What State? _____

Please rate your pain on a scale of 1 to 10 (10 being the most painful):

At Rest: 0 1 2 3 4 5 6 7 8 9 10

At its Worst: 0 1 2 3 4 5 6 7 8 9 10

Is the Pain:

- Worsening Stable Improving Constant
- Occasional Sharp Dull Aching
- Stabbing Throbbing Burning Intermittent
- Electrical Shock

What symptoms are you experiencing?

- Locking Catching Giving Way Popping
- Grinding Bruising Numbness Tingling
- Other (describe) _____

What, if anything, makes your symptoms better?

- Activity Heat Therapy Cold Therapy Brace/Bandage
- Rest Medication _____
- Other (describe) _____

What, if anything, makes your symptoms worse?

- Work Kneeling Bending Squatting
- Stairs Exercise Hills Prolonged Sitting
- Other: _____

Have you seen another physician for this injury?

Yes No If yes, who? _____

What treatments have you tried?

- Nothing Exercise Bracing Crutch/Walker
- Acupuncture Chiropractic
- Therapy (Date & Duration): _____
- Injections (i.e.: Synvisc, Hyalgan, Cortisone)
[Type & Date]: _____
- Medication _____
- Other _____

Have you had any of the following tests/studies?

Test	Date (month/year)
<input type="checkbox"/> X-rays	_____
<input type="checkbox"/> MRI scan	_____
<input type="checkbox"/> CT scan	_____
<input type="checkbox"/> EMG/NCV	_____
<input type="checkbox"/> Discogram	_____
<input type="checkbox"/> EKG	_____
<input type="checkbox"/> Blood tests	_____
Other	_____

What facility? (clinic/hospital)

PAST MEDICAL HISTORY

Check if you currently suffer or have previously suffered from

<input type="checkbox"/> High Blood Pressure	When? _____	<input type="checkbox"/> Osteoporosis	When? _____
<input type="checkbox"/> DVT/Blood Clots	_____	<input type="checkbox"/> Kidney Disease/Problem	_____
<input type="checkbox"/> Liver Disease	_____	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Heart Disease or Attack	_____	<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Thyroid <input type="checkbox"/> Hyper <input type="checkbox"/> Hypo	_____
<input type="checkbox"/> Cancer (where?)	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Elevated cholesterol	_____	<input type="checkbox"/> Pulmonary embolism	_____
<input type="checkbox"/> Ulcer disease	_____	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Gastritis/Peptic Ulcer	_____	<input type="checkbox"/> Rheumatic Fever	_____
<input type="checkbox"/> Reflux Disease (GERD)	_____	<input type="checkbox"/> Gout	_____
<input type="checkbox"/> GI/Stomach Bleed	_____	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Bleeding Disorders	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> HIV	_____
<input type="checkbox"/> Others, please list: _____		<input type="checkbox"/> STD	_____

Have you ever had a blood transfusion? Yes No If yes, when? _____

PAST SURGICAL/HOSPITALIZATION HISTORY

Please list all surgeries/hospitalizations you have had in the past

Type of Surgery/Hospitalization	Date	Doctor
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any problems with Anesthesia? Yes No Please explain if YES _____

ALLERGIES

Are you allergic to any medication? Yes No known drug allergies
 If YES, Please list all medications that you are allergic to and the associated reaction (i.e. Penicillin (hives) etc.) _____

Are you allergic to: Sulfa? Yes No Latex? Yes No Steroids? Yes No
 Please list all food allergies (i.e. eggs, shellfish): _____

MEDICATIONS

Please list all medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin, stomach medications, and any over the counter medications. Include Vitamin, Mineral and Herb supplements.

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

Work in the home Student Retired Employed
Occupation: _____
 Single Married Divorced Separated Widowed
Children? Yes No If yes, How Many? _____
Do you live alone? Yes No With whom? _____
Exercise? Daily Weekly Monthly Rarely Never
What type of exercise? _____

History of substance abuse? Yes No
What? _____
Smoke currently? Yes No _____ Packs/day for _____ years.
Quit Smoking? This year >1yr >5yrs >10yrs
Previously smoked _____ Packs/day for _____ years.
Alcohol use: No Daily 1-2x/wk 1-2x/month 1-2x/yr

FAMILY HISTORY

Please fill in family health status: (Blood Clots, Diabetes, Hypertension, Rheumatoid Arthritis, Cancer, Stroke, Heart Disease, Osteoporosis, Seizures, etc.)

	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Grandfather (mom's)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Grandmother (dad's)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Grandfather (dad's)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

REVIEW OF SYSTEMS

CONSTITUTIONAL:

YES NO

Weight Gain
 Weight Loss
 Weakness/Fatigue
 Fever
 Chills

VISION:

Blurred vision
 Eye pain
 Redness
 Glaucoma
 Blind
 Wear glasses/contacts

EARS, NOSE, THROAT:

Nose bleeds
 Hoarseness
 Ear Ache/Infection
 Ringing in ear
 Loss of hearing

CARDIOVASCULAR:

Chest pain
 Palpitations
 Swelling in legs
 Shortness of breath

RESPIRATORY:

Shortness of breath
 Frequent cough
 Wheezing/Asthma

Signature: _____

GASTROINTESTINAL:

YES NO

Heartburn
 Vomiting
 Nausea
 Abdominal pain
 Change in color of stool

GENITAL:

Enlarged prostate
 Venereal disease
 Pelvic pain
 Irregular menstruation
 Presently pregnant

URINARY:

Pain or burning with urination
 Frequent urination
 History of kidney stones
 Blood in urine
 Getting up at night to urinate

MUSCULOSKELETAL:

Instability
 Swelling of joints
 Stiffness
 Muscle ache
 Joint pain

NEUROLOGICAL:

YES NO

Headaches
 Seizures
 Dizziness
 Light-headedness (fainting)
 Tremor
 Numbness, tingling, loss of sensation

SKIN:

Itching
 Rash
 Psoriasis
 Redness
 Keloid Scars

ENDOCRINE:

Excessive thirst or hunger
 Hot/Cold intolerance
 Hot flashes

HEMATOLOGICAL:

Easily Bruised
 Excessive bleeding
 Varicose veins
 Blood clots

PSYCHOLOGICAL:

Depression
 Nervousness
 Anxiety
 Bipolar disease

Date: _____

Print Name: _____

PHYSICIANS CONSENT FOR TREATMENT

I hereby consent to treatment rendered to me by Lubbock Sports Medicine, Dr. Cord, Dr. Crawford, Dr. King, Dr. Scovell, and Dr. Shephard. This could include x-ray procedures, joint injection or aspiration, or manipulation of fractures, as well as any other treatment deemed necessary.

SIGNATURE:

Patient/Parent-Guardian Signature

Date

STUDENT-ATHLETE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize any medical provider of the Student-athlete listed below, associated with his/her school/organization/team, including Lubbock Sports Medicine, Dr. Stephen Cord, Dr. Kevin Crawford, Dr. Robert King, Dr. Field Scovell, Dr. David Shephard and other Lubbock Sports Medicine Providers, to release the Student-athlete's protected health information and related information regarding the Student-athlete's medical status, medical condition, injuries, illness, prognosis, diagnosis, injury rehabilitation, athletic participation status, related personally unidentifiable health information, and to provide emergency medical treatment. This protected health information may be released to the Student- athlete's parents/legal guardians, other health care providers, hospital and/or medical clinics and laboratories, physical therapists, athletic trainers, athletic coaches, athletic directors, and other medical personnel of the Student-athlete's school/organization/team.

I understand that my refusal to sign this authorization/consent for the disclosure of the Student-athlete's protected health information authorization may affect the Student- athlete's ability to participate in athletics at his/her school/organization/team.

I understand that my protected health information is protected by the federal regulations under the Health Information Portability and Accountability Act (HIPAA) and may not be disclosed without my authorization. I understand that once information is disclosed per authorization or consent, the information is subject to re-disclosure and may no longer be protected by HIPAA. I understand that I may revoke this authorization/consent at any time by notification in writing.

This authorization/consent for the disclosure of the Student-athlete's protected health information expires one year from the date it is signed.

REQUIRED SIGNATURE FOR PARTICIPATION:

Patient/Parent-Guardian Signature

Date

**ADVANCE PRACTICE NURSE
CONSENT FOR TREATMENT**

This facility has on staff an advance practice nurse to assist in the delivery of orthopedic care.

An advance practice nurse is not a doctor. An advance practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advance practice nurse can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advance practice nurse may treat minor lacerations and other minor injuries.

I have read the above and hereby consent to the services of an advance practice nurse for my orthopedic needs.

I understand that at any time I can refuse to see the advance practice nurse and request to see a physician.

Name: _____

Date: _____

Signature: _____

Melanie Choate, PA—C
Stan Kotara, PA—C
Ben Johnson, PA—C
Holly Short, PA—C

**PHYSICIAN ASSISTANT
CONSENT FOR TREATMENT**

This facility has on staff a physician assistant to assist in the delivery of orthopedic care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

Supervision does not require the constant physical presence of the supervising physician, but rather overseeing the activities and accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within their education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Supplying sample medications and writing prescriptions

I have read the above and hereby consent to the services of a physician assistant for my orthopedic needs.

I understand that at any time I can refuse to see the physician assistant and request to see a physician.

Name: _____

Date: _____

Signature: _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I _____ acknowledge that I have received a copy and have reviewed Lubbock Sports Medicine Notice of Privacy Practices. This notice describes how Lubbock Sports Medicine may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and my rights regarding my protected health information.

Patient-Signature/Parent-Guardian Signature

Date

If Parent-Guardian's Signature appears above, please describe Parent-Guardian's relationship to the patient: _____

Please indicate any persons authorized to discuss your PHI with our office or those who are authorized to receive copies of your medical records. Include the person's name and relationship to yourself. Include a start date and an end date to set restrictions of any individual(s).

NAME	RELATIONSHIP	START DATE	END DATE

I acknowledge receiving Lubbock Sports Medicine handouts for my own personal Information

- Financial Policy Letter
- Insurance Guidelines
- Office Policies
- Emergency Information Handout

Payment of Benefits and Terms

I understand that Lubbock Sports Medicine will bill my insurance company if I have provided adequate information. I authorize payment of benefits by my insurance company directly to Lubbock Sports Medicine. I acknowledge I am responsible for all charges incurred and understand deductibles and insurance co-payments are due at time of service. In the event that there is no insurance coverage and surgery is deemed necessary financial arrangements between Lubbock Sports Medicine and myself will need to be made. Lubbock Sports Medicine does not accept third-party Liability claims. I understand and agree to the above terms and information of Lubbock Sports Medicine.

Patient/Parent-Guardian Signature: _____

Date: _____

Witness Signature: _____

Date: _____

AGREEMENT AS TO GOVERNING LAW AND FORUM:

The patient or patient's representative and Lubbock Sports Medicine, including employees and agents of Lubbock Sports Medicine rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree:

(1) that all health care rendered shall be governed exclusively and only by Texas Law and in no event, shall the law of any other state apply to any health care rendered to patient; and

(2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas Court in the county/district where all or substantially all of the health care was provided or rendered and in no event, will any lawsuit, action or cause of action ever be brought in any other state.

The choice of law and forum selection provisions of this paragraph are mandatory and are not subject to change.

Patient Signature