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

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

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): ☐ Home ☐ Liability ☐ Motor Vehicle ☐ Job ☐ 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)	What facility? (clinic/hospital)
☐X-rays	_____	_____
☐MRI scan	_____	_____
☐CT scan	_____	_____
☐EMG/NCV	_____	_____
☐Discogram	_____	_____
☐EKG	_____	_____
☐Blood tests	_____	_____
Other	_____	_____

PAST MEDICAL HISTORY

Check if you currently suffer or have previously suffered from

	When?		When?
☐ High Blood Pressure		☐ Osteoporosis	
☐ DVT/Blood Clots		☐ Kidney Disease/Problem	
☐ Liver Disease		☐ Seizures	
☐ Heart Disease or Attack		☐ Arthritis	
☐ Stroke		☐ Thyroid ☐ Hyper ☐ Hypo	
☐ Cancer (where?)		☐ Tuberculosis	
☐ Elevated cholesterol		☐ Pulmonary embolism	
☐ Ulcer disease		☐ Polio	
☐ Gastritis/Peptic Ulcer		☐ Rheumatic Fever	
☐ Reflux Disease (GERD)		☐ Gout	
☐ GI/Stomach Bleed		☐ Asthma	
☐ Bleeding Disorders		☐ Diabetes	
☐ Hepatitis		☐ HIV	
☐ Others, please list:		☐ 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)	☐	☐	_____	_____
Grandfather (mom's)	☐	☐	_____	_____
Grandmother (dad's)	☐	☐	_____	_____
Grandfather (dad's)	☐	☐	_____	_____
Mother	☐	☐	_____	_____
Father	☐	☐	_____	_____
Sister/Brother	☐	☐	_____	_____
Sister/Brother	☐	☐	_____	_____
Sister/Brother	☐	☐	_____	_____

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

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

Signature:_____ Date:_____

Print Name:_____

PHYSICIANS CONSENT FOR TREATMENT

I hereby consent to treatment rendered to me by Lubbock Sports Medicine, Dr. Crawford, Dr. King, Dr. Campbell, Dr. Pankratz, 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. Crawford, Dr. King, Dr. Campbell, Dr. Pankratz, and Dr. 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:_____

Stan Kotara, PA—C
Holly Short, PA—C
Abigail Simpson, PA—C
Manny Hernandez, PA—C, ATC, LAT

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