



West Sports Medicine  
and Orthopaedics

## Patient Registration Form

Patient's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed  Other

Social Security Number: \_\_\_\_\_ Sex:  Female  Male DOB: \_\_\_\_\_

Phone #: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Race:  White  African American  Native American  Asian  American Indian  Other

Employment Status:  Employed  Unemployed  Student  Retired

Name of Employer: \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact Relationship to Patient: \_\_\_\_\_

Referring Provider Name: \_\_\_\_\_ Pharmacy: \_\_\_\_\_

### Responsible Party Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship to the Patient: \_\_\_\_\_

### Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Insured DOB: \_\_\_\_\_ Insured SS#: \_\_\_\_\_  Male  Female

Insured Employer: \_\_\_\_\_

**I agree that the above information supplied on this form is accurate to the best of my knowledge**

Patient (Responsible Party) Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Patient Consent Form

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures / tests
- Performance of other medically accepted laboratory test

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **West Sports Medicine & Orthopaedics** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **West Sports Medicine & Orthopaedics** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the *Notice of Privacy Practices*.

A photocopy of this consent shall be considered as valid as the original.

**Medicare Patients:** I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **West Sports Medicine & Orthopaedics**.

I acknowledge that I have been given the West Sports Medicine & Orthopaedics Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. **Patient Initials:** \_\_\_\_\_

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

**Patient (Responsible Party) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Consent to release medical records

I give **West Sports Medicine & Orthopaedics** and/or members of the office staff to release any or all medical information to specified person(s) other than you.  YES  NO

If yes, please specify to whom your medical information may be released to.

Authorized Person(s)	_____	Relationship to you	_____
	_____		_____
	_____		_____
	_____		_____
	_____		_____

I understand that as part of my continuing healthcare my physician maintains medical records in his/her office which contain my health history, symptoms, examination test results, diagnoses and treatment plans to be used as a basis for planning my care and treatment. This information may be released to my other physician(s) and/or healthcare provider(s).

I understand that I have the right to request restrictions as to how my medical records may be used or disclosed.

I understand that my physician keeps on the premises a copy of the "Notice of Privacy Practices for Protected Health Information" which provides a more complete description of the uses and disclosures of my medical records, and that I have been provided an opportunity to review this document prior to signing this consent. A written copy will be provided to me upon request.

I understand that my physician has the right to change this policy and that I will be notified in writing prior to any changes taking effect.

I understand that this document is a part of my permanent medical record, and that I may make changes regarding the disclosure of my health information as any time. I will notify West Sports Medicine & Orthopaedics of these changes in writing.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Financial Statement

Patients Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I agree to be personally responsible for any balance due on my account that is not covered by my insurance. Further, should my account be placed in collections, I will be responsible for any collection fees, attorney fees or court costs.

Patient Signature (Responsible Party): \_\_\_\_\_ Date: \_\_\_\_\_



West Sports Medicine  
and Orthopaedics

DAVID A WEST, D.O.

### NEW PATIENT HISTORY FORM

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Where you referred to our office by a physician? Yes  No  Whom? \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

Pharmacy Name, Location, Phone # \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

\_\_\_\_\_ Date symptoms started: \_\_\_\_\_

Is this a work related? Yes  No  Is this a sports injury? Yes  No  If yes, what sport? \_\_\_\_\_

Is this an injury from a motor vehicle accident? Yes  No  If yes, when? \_\_\_\_\_ what state? \_\_\_\_\_

Do you plan legal action regarding your injury? Yes  No

Have you retained an attorney? Yes  No  If yes, who? \_\_\_\_\_

List dates of work missed: \_\_\_\_\_

Have you received any treatment for this problem? Yes  No  If yes, what treatment have you received?

X-rays  MRI  CT/Myelogram  Bone Density Test  Surgery  Physical Therapy  EMG  Chiropractic

Pain Management  Injections  Other \_\_\_\_\_

#### Annual Medical History Information – Check all of your prior and current illnesses or conditions

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> High blood pressure        | <input type="checkbox"/> Stroke - Year: _____ | <input type="checkbox"/> Rheumatoid Arthritis              |
| <input type="checkbox"/> Heart Attack - Year: _____ | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Osteoarthritis                    |
| <input type="checkbox"/> Heart Disease              | <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Osteoporosis                      |
| <input type="checkbox"/> High Cholesterol           | <input type="checkbox"/> COPD                 | <input type="checkbox"/> HIV/AIDS                          |
| <input type="checkbox"/> Diabetes (Pills / Insulin) | <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Anxiety                           |
| <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Depression                        |
| <input type="checkbox"/> Kidney Stones              | location: _____                               | <input type="checkbox"/> Bipolar                           |
| <input type="checkbox"/> Blood Clots                | <input type="checkbox"/> Seizures             | <input type="checkbox"/> Addiction (alcohol, drugs)        |
| <input type="checkbox"/> Ulcers/Stomach problems    | <input type="checkbox"/> Migraines            | <input type="checkbox"/> Impotence (Males)                 |
| <input type="checkbox"/> Gastric Reflux             | <input type="checkbox"/> Chronic Headaches    | <input type="checkbox"/> Current Pregnancy (Females) _____ |
| <input type="checkbox"/> Thyroid Disease            | <input type="checkbox"/> Hepatitis _____      | <input type="checkbox"/> Date of last period _____         |
| <input type="checkbox"/> Other _____                | <input type="checkbox"/> Neuropathy           | <input type="checkbox"/> Sleep Apnea                       |

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Flu Vaccine: (year) \_\_\_\_\_ Pneumonia Vaccine: (year) \_\_\_\_\_

**Social History – Check all that apply**

Marital status:  Single  Married  Divorced  Widowed  Separated

Tobacco use:  None  Packs per day \_\_\_\_\_ x \_\_\_\_\_ years  Quit smoking (date) \_\_\_\_\_

Alcohol use:  None  Rarely  Socially  Daily

Recreational drug use:  None  Yes, what drug \_\_\_\_\_

Education level:  GED  High School  Some College  College Graduate  Post Graduate  Military

**Family History (mother, father, siblings, grandparents) – Check all that apply**

High Blood Pressure  Diabetes  Osteoporosis  Arthritis  Back Problems

Stroke  Heart Attack  Mental Illness  Scoliosis  Other \_\_\_\_\_

**Medication Allergies -**

**Surgical History – List all surgeries, include approximate date and surgeon.**

Surgery	Date	Surgeon

**Current Medication List**


Have you ever had problems with anesthesia?  NO  YES

Have you ever had problems with blood transfusions?  NO  YES

I acknowledge that all of the information above is complete and accurate. I hereby authorize West Sports Medicine & Orthopaedics physicians and staff to perform upon me or the above named patient an exam, x-rays, and/or tests required for the treatment of my Orthopaedic illness or injury.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_