ANDREWS
Sports Medicine and Orthopaedic Center

NAME: ______________________ ______________________ ______ ______________________
LAST FIRST M.I. NAME TO BE CALLED

TODAY'S DATE: __________ SEX: __________ DATE OF BIRTH: __________ SS# __________

ADDRESS: ____
STREET NUMBER & NAME OR P.O.BOX CITY STATE ZIP

HOME PHONE __________ WORK PHONE __________ CELL PHONE __________

PATIENT EMPLOYER: __________ EMAIL: __________

EMERGENCY CONTACT: __________ CONTACT # __________
NAME & RELATION OF PERSON OUTSIDE IMMEDIATE HOME

NAME OF SPOUSE: __________ SPOUSE EMPLOYER: __________

SCHOOL: __________ SPORT/OCCUPATION: __________

BODY PART: __________ LEFT ☐ RIGHT ☐

DATE INJURY/ACCIDENT OCCURRED: MONTH ☐ DAY ☐ YEAR ☐

HOW DID INJURY/ACCIDENT OCCUR: __________

DRUG ALLERGIES: ☐ YES ☐ NO __________
IF YES, PLEASE LIST ALL DRUG ALLERGIES

PRIMARY INS CO: __________ SECONDARY INS CO: __________

POLICY HOLDERS NAME: __________ POLICY HOLDERS NAME: __________

RELATIONSHIP TO PT: __________ RELATIONSHIP TO PT: __________

DATE OF BIRTH: __________ SS# __________ DATE OF BIRTH: __________ SS# __________

CONTRACT#: __________ GROUP#: __________ CONTRACT#: __________ GROUP#: __________

POLICY HOLDER'S EMPLOYER: __________ POLICY HOLDER'S EMPLOYER: __________

IS THIS A WORKMAN COMPENSATION CASE? YES ☐ NO ☐

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

DATE INJURY/ACCIDENT OCCURRED: MONTH ☐ DAY ☐ YEAR ☐

EMPLOYER: __________ WORK COMP CARRIER: __________

ADDRESS: ____
STREET NUMBER & NAME OR P.O.BOX CITY STATE ZIP

IF 19 YEARS OLD OR YOUNGER PLEASE COMPLETE THE FOLLOWING INFORMATION:

MOTHER'S NAME: __________
ADDRESS

HOME PHONE __________ WORK PHONE __________ CELL PHONE __________

FATHER'S NAME: __________
ADDRESS

HOME PHONE __________ WORK PHONE __________ CELL PHONE __________

LIST ANY COACH, ATHLETIC TRAINER, OR DOCTOR AND *COMPLETE ADDRESS* THAT YOU *WANT TO RECEIVE A REPORT:*

REFERRING DOCTOR: ______________________
NAME ADDRESS PHONE

FAMILY PHYSICIAN: ______________________
NAME ADDRESS PHONE

COACH/ATHLETIC TRAINER: ______________________
NAME ADDRESS PHONE

FAMILY MEMBER: ______________________
NAME ADDRESS PHONE

CURRENT MEDICATIONS: PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING ASPIRIN & SUPPLEMENTS

MEDICATIONS	DOSAGE	FREQUENCY	MEDICATIONS	DOSAGE	FREQUENCY
1			4		
2			5		
3			6		

DRUG ALLERGIES: ☐ YES ☐ NO ______________________
IF YES, PLEASE LIST ALL DRUG ALLERGIES

PREVIOUS HOSPITALIZATIONS/SURGICAL PROCEDURES: PLEASE PROVIDE DATES

TYPE OF SURGERY	YEAR	TYPE OF SURGERY	YEAR
1		3	
2		4	

FAMILY MEDICAL HISTORY: PLEASE LIST MEDICAL ILLNESS AFFECTING YOUR IMMEDIATE FAMILY (E.G. PARENTS & SIBLINGS)

DISEASE	FAMILY MEMBER	DISEASE	FAMILY MEMBER
1		3	
2		4	

SOCIAL HISTORY: CHECK APPROPRIATE BOXES & FILL IN BLANKS

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ OTHER

ALCOHOL: ☐ OCCASIONAL ☐ DAILY ☐ HEAVY ☐ NO CONSUMPTION

TOBACCO: ☐ YES ☐ NO YEARS USED ______ PACKS PER DAY ______ ☐ DRUGS

REVIEW OF SYSTEMS/GENERAL HISTORY: PLEASE CHECK ALL THAT APPLY

GENERAL
- ☐ WEIGHT CHANGE
- ☐ FEVER OR CHILLS
- ☐ AIDS/HIV
- ☐ NIGHT SWEATS
- ☐ BLEEDING
- ☐ LUMPS OR MASSES
- ☐ DIZZINESS OR FAINTING
- ☐ DIABETES MELLITUS
- ☐ THYROID PROBLEM
- ☐ CANCER

EAR-EYE-NOSE-THROAT
- ☐ VISUAL CHANGE
- ☐ HEARING CHANGE
- ☐ TINNITUS
- ☐ BLEEDING GUMS

MUSCULOSKELETAL
- ☐ BACKACHE
- ☐ JOINT PAIN
- ☐ JOINT SWELLING

GASTROINTESTINAL
- ☐ DYSPHAGIA DIFFICULTY IN SWALLOWING
- ☐ JAUNDICE
- ☐ HEPATITIS
- ☐ REFLUX
- ☐ ULCER

CARDIOVASCULAR
- ☐ CHEST PAIN
- ☐ HEART DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ MITRAL VALVE PROLAPSE
- ☐ THROMBOPHLEBITIS

RESPIRATORY
- ☐ COUGH/SPUTUM
- ☐ TUBERCULOSIS
- ☐ SHORTNESS OF BREATH
- ☐ ASTHMA
- ☐ EMPHYSEMA

GENITOURINARY
- ☐ URINARY INFECTIONS
- ☐ INCONTINENCE
- ☐ URINARY FREQUENCY
- ☐ VENERAL DISEASE
- ☐ MENOPAUSE

NEUROLOGIC
- ☐ SEIZURES
- ☐ NUMBNESS
- ☐ WEAKNESS

PSYCHOLOGICAL
- ☐ DEPRESSION
- ☐ BIPOLAR
- ☐ ADD/ADHD
- ☐ OTHER

SKIN
- ☐ ITCHING OR RASH

OTHER ILLNESS: ______________________

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.

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.

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.

Miscellaneous Provisions: 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.

UNDERSIGNED (Patient's Signature)	Signature - If signed by Undersign's Authorized Agent
WITNESS	RELATIONSHIP TO UNDERSIGNED
WITNESS - NEED ONLY IF SIGNATURES ARE MADE BY MARK (X)	MONTH DAY YEAR TIME A.M. P.M. DATE AND TIME OF SIGNING