



Tel 620-662-6000 | Toll-Free 1-877-662-6001  
Fax 620-662-6116 www.pinnacleortho.com  
1818 East 23rd | Hutchinson KS 67502-1106

Tel 316-283-9977 | Toll-Free 1-800-811-3183  
Fax 316-283-0966 www.pinnacleortho.com  
800 Medical Center Drive | Newton KS 67114

## SPORTS MEDICINE & ORTHOPAEDICS

I.D. # \_\_\_\_\_

Patient Name: \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status:  Single  Married  Widowed  Divorced

Home Address: \_\_\_\_\_ P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ E-mail address: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Spouse Name: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Spouse DOB: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

**Pharmacy & Location:** \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

I give permission for Pinnacle Sports Medicine & Orthopaedics to contact the patient's pharmacy for a list of medications.  Yes  No

**Race:**  Hispanic  Asian  Caucasian  Black/African American  American Indian or Alaska Native  Other: \_\_\_\_\_

**Ethnicity (Nationality-cultural background):** Hispanic/Latino  Non-Hispanic/Latino  Other

### -Complete if Student or Minor-

#### Father Information

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

Address: \_\_\_\_\_

City, St., Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_

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

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

#### Mother Information

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

Address: \_\_\_\_\_

City, St., Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_

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

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

### -Person Responsible for Payment of Account-

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

City, St., Zip: \_\_\_\_\_ Other Phone: ( ) \_\_\_\_\_

### -Insurance Information-

*Please Present Card(s) for Copying*

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Ins. Address: \_\_\_\_\_ Ins. Phone: \_\_\_\_\_

Card Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Ins. Address: \_\_\_\_\_ Ins. Phone: \_\_\_\_\_

Card Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Other Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Ins. Address: \_\_\_\_\_ Ins. Phone: \_\_\_\_\_

Card Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

I hereby give my consent to Pinnacle Sports Medicine & Orthopaedics and its business associates to use and disclose my protected health information for the purpose of treatment, payment, and health care operations as noted in the Notice of Privacy Policies provided to me by the practice. I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full. If Pinnacle Sports Medicine & Orthopaedics chooses to accept assignment of my health insurance benefits, I hereby assign all payments to which I am entitled. I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I take full responsibility for all costs incurred by my failure to pay for services rendered.

**Signature of Patient or Patient's Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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**-Acknowledgement of Receipt of Privacy Notice-**

I acknowledge that I have received a copy of Pinnacle Sports Medicine & Orthopaedics' Notice of Privacy Practices effective April 2003.

**-Authorization for Medical Care-**

I hereby authorized Pinnacle Sports Medicine & Orthopaedics to give me medical treatment for any and all conditions they deem appropriate. I understand that the doctor or other provider will discuss with me their recommendations for testing and/or treatment that in their professional judgment they feel is appropriate for my needs

**-Referral Waiver-**

I acknowledge that in the course of my treatment, Pinnacle Sports Medicine & Orthopaedics, may refer me to other health care facilities and/or providers for diagnostic tests, treatment, or consultation. Pinnacle Sports Medicine & Orthopaedics will notify me when such a referral occurs. I understand that Pinnacle Sports Medicine & Orthopaedics does not know whether the facility or provider they are referring me to is a contracting provider with my insurance plan. I agree that should Pinnacle Sports Medicine & Orthopaedics make such a referral, it is my responsibility to verify my insurance coverage, eligibility, pre-certification (if applicable), and whether or not the facility or provider that Pinnacle Sports Medicine & Orthopaedics refers me to contracts with my insurance company. Pinnacle Sports Medicine & Orthopaedics is not responsible should my insurance process claims at the non-contracting level for the referred service(s).

**-Release of Information-**

We are often contacted and asked to give details on the patient's appointment, billing information or condition. If you are not present at the time such a request is made (e.g., over the telephone) we will follow your prior instructions in determining whether we should share any information, or we will contact you before providing any specific response.

**Please indicate your preferences below:**

1.  Do NOT share ANY information with anyone (self only)
2.  Share information with the people listed below upon their request, unless I specifically direct you, in writing, not to share certain information. (parent, spouse, children, etc)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Coach and/or Athletic Trainer's Name: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Date





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I.D. # \_\_\_\_\_

**PROBLEM or ACCIDENT/INJURY INFORMATION**

1. What are we seeing you for today? \_\_\_\_\_

**What body part?** \_\_\_\_\_ Right or Left

2. Have you had x-rays of this area? \_\_\_\_\_ If yes, what facility? \_\_\_\_\_

3. Is this an injury? Yes No

**Type:** Motor Vehicle Sports Injury Worker's Compensation Liability Other: \_\_\_\_\_

4. Injury Date: \_\_\_\_\_ How did injury occur: \_\_\_\_\_

What body part injured: \_\_\_\_\_ Where did injury occur: \_\_\_\_\_

5. Is there legal action pending related to your problem?  Yes  No

If yes, attorney's name \_\_\_\_\_

6. Have you been treated by another healthcare provider for this problem?  Yes  No

If yes, name of provider(s) \_\_\_\_\_

7. Please check any treatments or tests you have had for this problem prior to today's visit.

Chiropractic  Injections  Surgery  Physical Therapy  MRI  CT Scan  Bone Scan

Nerve Conduction Test  Lab tests  X-rays **Do you have the X-rays with you?**  Yes  No

Where was the service provided? \_\_\_\_\_



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**NEW PROBLEM QUESTIONNAIRE FOR ONE PROBLEM ONLY**

**Onset:**  Gradual  Sudden **On a scale from 1-10, rate your pain,** 1-slight - 10-unbearable \_\_\_\_\_

**Radiation:**  Yes  No Radiates to: \_\_\_\_\_

**Frequency:**  Intermittent  Occasional  Constant  Rare

**Status:**  Changing  Fluctuating  Stable  Worse  Improving  Resolved

**Quality:**  Aching  Burning  Dull  Piercing  Sharp  Throbbing  Other \_\_\_\_\_

**Aggravated by:**

- Bending  Lifting  Sitting  Nothing
- Climbing Stairs  Movement  Standing  Other: \_\_\_\_\_
- Descending Stairs  Pushing  Walking

**Relieved by:**

- Brace/Splint  Ice  Mobility  Stretching
- Elevation  Injection  OTC Meds  Other: \_\_\_\_\_
- Exercise  Massage  Physical Therapy  Nothing
- Heat  Pain/RX Meds  Rest

**Associated Symptoms:**

Please mark the symptoms you are experiencing

- Bruising  Limping  Spasms
- Crepitus  Locking  Swelling
- Decreased mobility  Nocturnal awakening  Tingling in the arms
- Difficulty initiating sleep  Nocturnal pain  Tingling in the legs
- Joint instability  Numbness  Weakness
- Joint tenderness  Popping  **No concerns with any of these**

Other associated symptoms: \_\_\_\_\_

**REVIEW OF SYSTEMS**

Do you currently have any of these problems?

<b>Constitutional</b>	<b>Gastrointestinal</b>	<b>Psychiatric</b>	
<input type="checkbox"/> Chills	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Anxiety	
<input type="checkbox"/> Fever	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Depression	
<b>HEENT</b>	<b>Genitourinary</b>	<b>Skin</b>	
<input type="checkbox"/> Headache	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Skin infection	
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Rash	
<b>Respiratory</b>	<b>Metabolic</b>	<b>Hematologic</b>	
<input type="checkbox"/> Cough	<input type="checkbox"/> Cold intolerant	<input type="checkbox"/> Easy Bleeding	
<input type="checkbox"/> Short of breath	<input type="checkbox"/> Heat intolerant	<input type="checkbox"/> Easy bruising	
<b>Cardiovascular</b>	<b>Neurologic</b>	<b>Immunologic</b>	
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Trouble walking	<input type="checkbox"/> Asthma	
<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Seizures	<input type="checkbox"/> Allergies	
		<input type="checkbox"/> Seasonal	<input type="checkbox"/> Food

**NONE OF THESE APPLY TO ME**

**Office Use Only:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_





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**MEDICAL HISTORY**

Please select any problems you currently have or have had in the past.

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Aids/HIV            | <input type="checkbox"/> COPD               | <input type="checkbox"/> Heart disease / attack | <input type="checkbox"/> Rheumatoid arthritis             |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Depression         | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Seizure disorders                |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Hypertension           | <input type="checkbox"/> Sleep apnea                      |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Drug abuse         | <input type="checkbox"/> High cholesterol       | <input type="checkbox"/> Stomach ulcer                    |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Fibromyalgia       | <input type="checkbox"/> Kidney disease         | <input type="checkbox"/> Stroke                           |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Gout               | <input type="checkbox"/> Liver disease          | <input type="checkbox"/> Thyroid problems                 |
| <input type="checkbox"/> Blood clots         | <input type="checkbox"/> Heartburn / reflux | <input type="checkbox"/> Osteoarthritis         | <input type="checkbox"/> Other: _____                     |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart failure      | <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> <b>NONE OF THESE APPLY TO ME</b> |

Type: \_\_\_\_\_

**SURGICAL HISTORY**

Please list all previous surgeries and the approximate year:

Surgery: _____	Year: _____
_____	_____
_____	_____
_____	_____
_____	_____

**I HAVE NOT HAD ANY SURGERIES**

Surgery: _____	Year: _____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY	Mother	Father	Sister	Brother	Grandmother (Maternal)	Grandfather (Maternal)	Grandmother (Paternal)	Grandfather (Paternal)	Child	Other
Asthma										
Blood clots										
Cancer										
Diabetes										
Gout										
Heart disease										
Hypertension										
Kidney disease										
Liver disease										
Lupus										
Osteoarthritis										
Osteoporosis										
Rheumatoid arthritis										

