

Patient Name:

Patient:



**1818 East 23rd Avenue
Hutchinson, KS 67502
620-662-6000
Toll Free 1-877-662-6001**



Demographics		Visit Date:		<input type="checkbox"/> JIL <input type="checkbox"/> ELS <input type="checkbox"/> TP Other Provider: _____	
Patient Name (Last)		(First)		(Middle)	
Street Address				<input type="checkbox"/> Male <input type="checkbox"/> Female	
City		State	Zip Code		
Home Phone ()		Work Phone ()		Cell Phone ()	
E-mail address					
Date of Birth / /		Age	Social Security #		
Patient Employer			Occupation		
Patient Employer Address			City/State		Zip Code
Patient Employer Phone ()					
Name of your Primary Care Physician (PCP):					
How Did You Hear About Us? <input type="checkbox"/> Physician _____ <input type="checkbox"/> Patient: _____ <input type="checkbox"/> Employee _____ <input type="checkbox"/> Feist Phonebook <input type="checkbox"/> Southwestern Bell Phonebook <input type="checkbox"/> Hutchinson News <input type="checkbox"/> Other _____					
We will send a letter to your referring physician. If your primary care physician (PCP) is not the same as your referring physician, would you like us to also send a letter to your PCP regarding your visit today? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Who is the Guarantor/Responsible Party for this Account? Please fill in if patient is under 18 yrs old.					
<input type="checkbox"/> Guarantor is same as Patient (If so, skip this section)					
Name		Date of Birth / /			
Address					
City		State	Zip Code		
Relation to Patient			Social Security #		
Home Phone			Work Phone		
Guarantor's Employer				Phone	
Guarantor's Employer Address					
Guarantor's Employer City		State	Zip Code		
In case of Emergency, name of friend or relative NOT LIVING with you					
Name					
Relationship			Phone		

Patient Name:

Patient:

What Insurance's Will You Be Using For Your Visit Today? (Please complete the information for those that apply)

Primary Company	Phone
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Who is the Primary Insurance Company Card Holder? (The person whose name appears on the insurance card.)

Primary Insured is same as Patient (If so, skip this section) Primary Insured is same as Guarantor (If so, skip this section)

Name	Date of Birth	/	/
Address			
City	State	Zip Code	
Relation to Patient	Social Security #		
Home Phone	Work Phone		
Insured's Employer			Phone
Insured's Employer Address			
Insured's Employer City	State	Zip Code	

Will you be using a Secondary Insurance? If none, skip this section.

Secondary Company	Phone
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Who is the Secondary Insurance Company Card Holder? (The person whose name appears on the insurance card). If none, skip this section

Secondary insured is same as Patient (if so, skip this section) Secondary insured is same as Guarantor (if so, skip this section) Secondary insured is same as Primary insured (if so, skip this section)

Name	Date of Birth	/	/
Address	Relation to Patient		
City	State	Zip Code	
Relation to Patient	Social Security #		
Home Phone	Work Phone		
Secondary Insured's Employer			Phone
Secondary Insured's Employer Address			
Secondary Insured's Employer City	State	Zip Code	

Work Comp/Auto/Liability Ins. Company

Company Name	Phone	
Address		
City	State	Zip Code
Adjuster's Name	Claim #	
Claim should be filed with: <input type="checkbox"/> Employer <input type="checkbox"/> Insurance Company		

Patient Name:

Patient:

Current History

What is the main reason you came to the office today?

Details Relevant to Your Visit

Was your visit caused by an Accident/Injury? Yes No Not Applicable

Accident/Injury Date (month/day/year) (/ /)

Provide details on how the accident or injury occurred.

Where did the accident/injury occur? Work Home Auto Other _____

Is this a workers' compensation or auto claim? Workman's Comp Auto Neither

Is an attorney involved? Yes No

Attorney Name

Attorney Phone

X-Rays Did you have X-rays taken at another location? Yes No X-Ray Date / /

Where were the X-rays taken Do you have the X-rays with you? Yes No

What is your usual work (describe)?

What sports, hobbies, leisure or activities do you engage in?

Patient Name:

Patient:

Past Medical History

Do you have any **chronic** medical problems or **current** medical problems? Yes No.

<input type="checkbox"/> Asthma	<input type="checkbox"/> Seizures	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Anemia
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Cancer
<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Latex Sensitive	<input type="checkbox"/> Other:	<input type="checkbox"/>

When was the first day of your last menstrual period: Not Applicable Date (/ /)

Have you ever had any sexually transmitted diseases? Yes No
(If yes, please circle: Gonorrhea, Chlamydia, Hepatitis B, Hepatitis C, HIV/AIDS, Syphilis)

Past Medical History (continued)

List any surgeries you have had:

Year	Surgery

List prior hospitalizations (other than surgeries or deliveries):

Year	Cause/Illness

Family History

Does anyone in your immediate or extended family have any of the following problems:

Disease	Yes/No	Who	Describe
Diabetes			
Heart disease			
High cholesterol			
Strokes			
High blood pressure			
Osteoporosis or weak bones or broken hips			
Alzheimer's			
Blood clots in legs, lungs or brain			
Cancer			
Alcohol or drug use			
Bleeding disorders			

Patient Name:

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Social History

What race are you?	Are you: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No. How much?	How long?
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No. How much?	
Have you ever used any street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No.	
<i>When</i>	<i>What</i>

Review of Systems Please mark any of the following symptoms that you currently have No concerns with these

<input type="checkbox"/> Recent weight change <i>Specify:</i>	<input type="checkbox"/> Cough	<input type="checkbox"/> Pain or discomfort with urination
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Fever	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Skin rashes or sores	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Incontinence (loss) of stool or gas
<input type="checkbox"/> Unusual headaches	<input type="checkbox"/> Earaches	<input type="checkbox"/> Leg cramps
<input type="checkbox"/> Fainting	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Head injuries	<input type="checkbox"/> Nasal congestion	<input type="checkbox"/> History of blood clots in legs/lungs
<input type="checkbox"/> Vision problems	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Back problems
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Trouble swallowing	<input type="checkbox"/> Easy bruising
<input type="checkbox"/> Dental Problems	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Intolerance to heat or cold
<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Mitro Valve Prolapse	<input type="checkbox"/> Memory problems
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Depression
<input type="checkbox"/> Lumps in neck	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Change in bowel movements
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Bloody or black tarry stools
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Constipation/Hemorrhoids	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Numbness (location)	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Artificial Joint
<input type="checkbox"/> Tingling (location)		

List any medications you are taking:

Prescription: None

Non-Prescription (include vitamins, supplements, herbs, etc.) None

Do you have any allergies to medications? Yes No.

Describe/List

Please initial at each section below:

AUTHORIZATION FOR MEDICAL CARE: I hereby authorized Pinnacle Sports Medicine & Orthopaedics, P.A. 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.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby assign payment directly to Pinnacle Sports Medicine & Orthopaedics, P.A. for surgical and/or medical benefits, if any, otherwise payable to me for services as described, but not to exceed my indebtedness to Pinnacle Sports Medicine & Orthopaedics, P.A. for those services.

INSURANCE INFORMATION RELEASE AUTHORIZATION: I hereby authorize Pinnacle Sports Medicine & Orthopaedics, P.A. to release any information acquired in the course of my examination or treatment to my referring doctor and/or my insurance company or employer (employer only if visit is work related).

FINANCIAL OBLIGATIONS: I hereby agree to abide by Pinnacle Sports Medicine & Orthopaedics, P.A. Credit & Payment Policy dated June 15, 2003. I understand that if my insurance company has not paid within sixty (60) days, the balance will automatically become my responsibility.

AUTHORIZATION TO SEND EMAIL: I hereby agree to allow Pinnacle Sports Medicine & Orthopaedics, P.A. to send me periodic email.

NOTICE OF PRIVACY PRACTICES ACT: I acknowledge that I have received and read Pinnacle Sports Medicine & Orthopaedics, P.A. Notice of Privacy Practices dated April 2003.

REFERRAL WAIVER: I acknowledge that in the course of my treatment, Pinnacle Sports Medicine & Orthopaedics, P.A., 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).

I, _____, have initialed the above sections and provide my
(print name)
signature below acknowledging my approval and agreement with the same.

PATIENT'S SIGNATURE _____ DATE _____

PARENT OR
GUARDIAN'S SIGNATURE _____ DATE _____

(If patient is under the age of 18)

Patient Name:

Patient:



1818 East 23rd Ave
 Hutchinson, KS 67502 - 1106

Authorization to Disclose Information to Those Involved in My Care

Re: _____
 Last Name (Maiden Name) First Name Middle Initial Date of Birth

 Address City State Zip Phone Number

I hereby allow Pinnacle Sports Medicine & Orthopaedics to disclose the following Protected Health Information:

- Appointment times and dates
- Tests that have been received
- Test results
- Other health information
- All information (health & billing)
- All health information
- Billing information - Specify Dates: _____
- All billing information

to the following people because they are involved with my health care or payment:
 (Please print full name)

- Self
- Spouse _____
- Family friend _____
- Child(ren) _____
- Other _____

In the following forms of communication:

- Home telephone number _____
- Work telephone number _____
- Home voice messaging system _____
- Work voice messaging system _____
- Cellular phone _____
- Other _____

Signed: _____
 Patient (or Legal Representative and Relationship)

Date: _____