

**PREMIER ORTHOPEDIC SURGERY AND SPORTS MEDICINE  
PATIENT HEALTH HISTORY**

In order for us to obtain a complete medical history it is important for you to fill this out as completely and accurately as possible. The information will then be entered in your electronic chart and become part of your record

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height: ft \_\_\_\_ in \_\_\_\_ Weight: \_\_\_\_\_ lbs.

Name of Primary Care Physician: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

**Please list medications you are currently taking:**

Medication/Dosage: \_\_\_\_\_  
Medication/Dosage: \_\_\_\_\_  
Medication/Dosage: \_\_\_\_\_  
Medication/Dosage: \_\_\_\_\_  
Medication/Dosage: \_\_\_\_\_  
Medication/Dosage: \_\_\_\_\_  
Medication/Dosage: \_\_\_\_\_

**Medication Allergies** \_\_ Yes\_\_ No... If yes please see below

Medication/Reaction: \_\_\_\_\_

Medication/Reaction: \_\_\_\_\_

Medication/Reaction: \_\_\_\_\_

**Non-Medication Allergies** \_\_\_\_ Yes \_\_\_\_ No....If yes please see below

Allergy/Reaction: \_\_\_\_\_

Allergy/Reaction: \_\_\_\_\_

Allergy/Reaction: \_\_\_\_\_

**PREMIER ORTHOPEDIC SURGERY AND SPORTS MEDICINE  
PATIENT HEALTH HISTORY**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_

**Past Medical History:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Surgeries and Hospitalizations:**

Have you ever had any surgeries \_\_\_\_yes \_\_\_\_no?

If yes please list: \_\_\_\_\_

Have you ever had any problems with anesthesia \_\_\_\_yes \_\_\_\_no?

If yes please describe reaction: \_\_\_\_\_

Have you been hospitalized for any non surgical reasons? \_\_\_\_yes \_\_\_\_no?

If yes please list reason for hospitalizations: \_\_\_\_\_

Most-recent occupation: \_\_\_\_\_

# ***Premier Orthopedic Surgery & Sports Medicine, PLLC***

## **PATIENT FINANCIAL RESPONSIBILITY/AUTHORIZATION FORM**

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

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

1. **FINANCIAL RESPONSIBILITY:** We are pleased to assist with your insurance. I understand that with the exceptions explained below, I am personally responsible for any medical fees I will incur with Premier Orthopedic Surgery & Sports Medicine, PLLC. I also understand **that I will be responsible for any charges incurred by not providing the most current & correct insurance including an HMO referral if required to Premier Orthopedic Surgery & Sports Medicine, PLLC.** Exceptions to this policy are those patients with a current authorization with an HMO, a State or Federally funded program, or PPO in which Premier Orthopedic Surgery & Sports Medicine, PLLC is currently a contracted provider.

\_\_\_\_\_  
**\*\*\*Signature of Patient or Legal Guardian**

2. **AUTHORIZATION TO RELEASE INFORMATION/MEDICATION SEARCH: I HERBY AUTHORIZE** Premier Orthopedic Surgery & Sports Medicine, PLLC to release medical information acquired in the course of my examination or treatment, to my insurance company, or other physicians required to participate in my care. I authorize Premier Orthopedic Surgery & Sports Medicine, PLLC to do a medication search prior to giving me a prescription for a controlled substance.

\_\_\_\_\_  
**\*\*\*Signature of Patient or Legal Guardian**

3. **AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** I hereby authorize payment for medical services provided directly to Premier Orthopedic Surgery & Sports Medicine, PLLC physicians.

\_\_\_\_\_  
**\*\*\*Signature of Patient or Legal Guardian**

4. **ACKNOWLEDGE OF RECEIPT OF PRIVACY POLICY:** I acknowledge that I have received a copy of Premier Orthopedic Surgery & Sports Medicine, PLLC Privacy Policy.

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**\*\*\*Signature of Patient or Legal Guardian**

# PREMIER ORTHOPEDIC SURGERY AND SPORTS MEDICINE, PLLC

## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to Premier Orthopedic Surgery and Sports Medicine, PLLC (the "Practice") using and disclosing my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I hereby acknowledge that I have had the right to review the Practice's Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that the Practice reserves the right to revise its Privacy Policy at anytime. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request for same to the Practice.

### **Consent to Calls/Mail/Email**

I hereby consent to the Practice calling my home, cell phone or other designated location and leaving a message on my voicemail or in-person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment. You may leave information with: \_\_\_\_\_

I hereby consent to the Practice mailing to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I hereby consent to the Practice e-mailing me any items or communications that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements.

I understand that I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

**By signing this form**, I am consenting to the Practice's use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information.

I understand that I may revoke my consent in writing, except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that the Practice may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number(s) (Cell/Home/Work)

\_\_\_\_\_  
Email Address

