WESTCHASE SPORTS MEDICINE

(Please Print)

Patient Information

Today's Date _____Home Phone _____

Name _____ SS# _____

Address _____Cell Phone _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birth date _____ ☐ Married ☐ Widow ☐ Single ☐ Divorced/Separated ☐ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Phone _____

Emergency Contact _____ Phone _____

Family/Referring Dr _____Phone _____Fax _____

Primary Insurance please give receptionist your photo ID and insurance cards

Insured Name _____ DOB _____

Address if different then above _____ Phone _____

City _____ State _____ Zip _____ SS# _____

Insured Employer _____ Wk Phone _____

Insurance Company _____

Subscriber ID # _____ Group # _____

Insurance Address _____ Phone _____

City _____ State _____ Zip _____ Fax# _____

Do you have secondary Insurance? ☐ Yes ☐ No Insurance Company _____

Workers Compensation or MVA information

Claim Number _____ Date of Injury _____

WC MVA Company Name _____ Phone _____

Address for Claims _____

Adjuster Name _____Phone _____Fax _____

Nurse Case Manager _____Phone _____Fax _____

Attorney Name _____Phone_____Fax _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize MacLaren Sports Medicine Inc. or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature Date

WESTCHASE SPORTS MEDICINE

Patient History

Patient: _____Age: _____DOB: _____

Date:_____Height: _____Weight: _____WC MVA DOI/DOA: _____DOS:_____

What is the main reason you are here for: _____
_____

Medications

1._____ 2._____ 3._____
4._____ 5._____ 6._____
7._____ 8._____ 9._____
10._____ 11._____ 12._____

ARE YOU ALLERGIC TO ANY MEDICATIONS: YES NO If so what_____
_____

Past Medical History

Check all that apply

_Diabetes _High Blood Pressure _Heart Disease _Heart Attack
_Asthma _Bronchitis or Emphysema _Pneumonia _Ulcers
_Hypo/Hyper Thyroid _Rheumatoid Arthritis _History of Cancer _Blood Clots
_High Cholesterol _Other:_____ type: _____

Past Surgical History

_Appendix (Appendectomy) _Breast Surgery _Tonsillectomy
_Gall Bladder (Cholecystectomy) _Back Surgery _Hysterectomy
_Heart Bypass _Total Joint Replacement _Arthroscopy
_Prostate _Other:_____ _Other:_____

Family Medical History

Has anyone in your immediate family died of heart disease: Yes No
Has anyone in your family had an adverse reaction to anesthesia: Yes No
List any medical illnesses that run in your family: _____
_____

Social History

Who do you live with now: SPOUSE BY YOURSELF OTHER FAMILY FRIENDS OTHER _____
Do you smoke tobacco? YES NO How much? _____ packs per day How long? _____ years
Do you drink alcohol? YES NO How much? _____drinks per day How long? _____years

DO YOU NOW OR HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING?

Constitutional Symptoms
Fever Y N
Chills Y N
Headache Y N
Other _____

Eyes
Blurred Vision Y N
Double Vision Y N
Pain Y N
Other _____

Allergic
Hay Fever Y N
Drug Allergies Y N
Other _____
_____

Ear/Nose/Throat
Ear infection Y N
Sore Throat Y N
Sinus Problems Y N

Genitourinary
Unrine Retention Y N
Painful Unination Y N
Urinary Frequenc Y N

Neurological
Tremors Y N
Dizzy Spells Y N
Numbness/Tingling Y N

Endocrine
Excessive Thirst Y N
Too hot/cold Y N
Tired/Sluggish Y N

Gastrointestional
Abdominal Pain Y N
Nausea/Vomiting Y N
Rectal Bleeding Y N
Ulcers Y N

Respiratory
Frequent Cough Y N
Short of Breath Y N
Wheezing Y N

Hemotologic/Lymphatic
Swollen Glands Y N
Blood Clots Y N
Bleeding Prob. Y N

Cardiovascular
Chest Pain Y N
Varicose Veins Y N
High B.P. Y N
Other _____

Integumentary
Skin Rash Y N
Boils Y N
Persistent Itch Y N
Other _____

Musculoskeletal
Joint Pain Y N
Neck Pain Y N
Back Pain Y N
Other _____

Psychologic
History of depression Y N
History of bipolar disorder Y N
History of schizophrenia Y N

Other Medical Conditions: _____

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Medical Records Release Authorization

In order to avoid a delay this form must be completed in its entirety.
PLEASE PRINT CLEARLY

Patient Name:_____ Maiden Name:_____

D.O.B. **(Required)**_____ SS#**(Required)**_____

Home Phone:_____ Work Phone: _____

Permission is hereby granted to Westchase Sports Medicine to release medical information to the individual/organization as noted below or to have records released to Westchase Sports Medicine:

☐ Mail to: Name:_____

Address:_____

City/State/Zip:_____

☐ Fax to another medical entity (____)_____ ☐ call when ready for pick up (____)_____ ☐ Person picking up records

Please check information to be released:

☐ All records, excluding records from other physicians.
☐ Surgical Records
☐ Therapy reports
☐ Diagnostic test results
☐ Other _____
☐ Office Notes only
☐ X-ray/MRI films
☐ X-ray/MRI reports
☐ Patient information

This authorization will be valid for two years after the date of the patient's signature as it appears below, or by whichever comes sooner._____
Date

I understand I have the right to refuse this authorization, in writing, and Westchase Sports Medicine is released from all legal liability that may arise from the released information requested.

_____ _____
Signature of patient/Legal Guardian Date

WESTCHASE

SPORTS MEDICINE

AUTO ACCIDENT PATIENT QUESTIONNAIRE

PATIENT: _____

DATE OF ACCIDENT: _____

LOCATION OF ACCIDENT: _____

WERE YOU WEARING A SEAT BELT? _____

WERE YOU THE DRIVER OR PASSENGER? _____

IF PASSENGER, WERE YOU IN THE FRONT OR THE BACK SEAT? _____

DESCRIBE THE ACCIDENT IN YOUR OWN WORDS: _____

_____

_____

_____

WERE YOU STRUCK IN THE FRONT, REAR, DRIVER SIDE OR PASSENGER SIDE OF THE VEHICLE? ____

_____

WERE YOU KNOCKED UNCONCIOUS? _____IF YES, HOW LONG? _____

DID YOU FEEL IMMEDIATE PAIN? YES NO WHERE? _____

DID YOU GO TO THE HOSPITAL? YES NO HOSPITAL _____

WERE THERE X-RAYS TAKEN? _____MEDICATION GIVEN?_____

WHAT WAS YOUR DIAGNOSIS? _____

HAVE YOU BEEN TREATED BY ANOTHER PHYSICIAN SINCE THE ACCIDENT? _____

NAME OF PHYSICIAN: _____TREATMENT: _____

DID YOU HAVE SYMPTOMS PRIOR TO THE ACCIDENT? _____

ARE THE SYMPTOMS IMPROVING, GETTING WORSE OR THE SAME? _____

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT BEFORE? _____

DATE(S) AND INJURY(S): _____

_____