PATIENT HISTORY
BEACON ORTHOPAEDICS & SPORTS MEDICINE

Name ______________________ Age: ________ DOB: ____________ Date: ____________

Chief Complaint ______________________

Was this due to an injury or accident? Yes ____ No ____ Date of Injury____________ Did this occur at work? Yes _____ No _____

Has this injury been treated? Yes ____ No _____ If yes, how has this been treated and by whom? ______________________

____

Have you had a previous similar injury? Yes ____ No _____ Please explain: ______________________

Current weight ________ 1 Year Ago ________ Height _______ Blood Pressure: __________ Occupation: ______________

Marital Status: S___ M___ W___ D___ Do you live alone? Yes ____ No ___ Hobbies/Sports: ______________

Do you smoke? Yes ____ No _____ If yes, how many per day? ________

Do you consume alcohol? Yes ____ No ___ If yes, how much per week? ____________

Name of Primary Care Physician: ______________________

Drug Allergies: ______________________

Current Medications: ______________________

____

Hospitalizations or surgeries? ______________________

____

Have you ever had a blood transfusion? Yes ____ No _____ If yes, date ____________

PLEASE USE BACK OF FORM TO ADD ANY OTHER PERTINENT INFORMATION

Have you or your family members had any of the following conditions (Please check all that apply)

	Self		Mother		Father		Children/Other Relatives	
	Yes	No	Yes	No	Yes	No	Yes	No
Heart Disease	___	___	___	___	___	___	___	___
High Blood Pressure	___	___	___	___	___	___	___	___
Stroke	___	___	___	___	___	___	___	___
Cancer	___	___	___	___	___	___	___	___
Glaucoma	___	___	___	___	___	___	___	___
Diabetes	___	___	___	___	___	___	___	___
Epilepsy/Convulsions	___	___	___	___	___	___	___	___
Bleeding Disorder	___	___	___	___	___	___	___	___
Thyroid Disease	___	___	___	___	___	___	___	___
Mental Illness	___	___	___	___	___	___	___	___
Osteoporosis	___	___	___	___	___	___	___	___
Tuberculosis	___	___	___	___	___	___	___	___
Kidney Disease	___	___	___	___	___	___	___	___

For Women Only:
Pregnant. Yes ____ No ____

Are there any other serious illnesses/health conditions affecting you or your family of which we should be aware? Yes__ No __

____

____

____

____

Please check if you have ever had the symptom listed – Check all that apply

CONSTITUTIONAL
__ Fever
__ Weight Loss
__ Fatigue

EYES
__ Double Vision
__ Blurring
__ Trauma

ENT/MOUTH
__ Deafness
__ Sinusitis
__ Ringing in Ears
__ Dizziness
__ Balance Problems

CARDIOVASCULAR
__ Chest Pain
__ Heart Murmur
__ High Blood Pressure
__ Heart Attack
__ Irregular Rhythm

RESPIRATORY
__ Shortness of Breath
__ Asthma
__ Lung Disease
__ Bronchitis
__ Pneumonia

GI
__ Weight Change
__ Diarrhea
__ Constipation
__ Ulcer
__ Gallbladder Disease
__ Change in Bowel Habits

GU
__ Leaking Urine
__ Prostate Disease
__ Pain with Urination
__ Frequent Urination
__ Kidney Stones

MUSCULOSKELETAL
__ Fracture
__ Pain
__ Swelling
__ Arthritis
__ Spasm/Muscle
__ Gout
__ Rheumatoid Arthritis

NEUROLOGICAL
__ Seizures/Epilepsy
__ Weakness
__ Stroke
__ Headaches
__ Blackouts/Fainting
__ Tremble
__ Head Injuries

PSYCH
__ Depression
__ Sleep Disorder
__ Memory Problems

VASCULAR
__ Blood Clots
__ Poor Circulation

HEMATOLOGIC
__ Hepatitis
__ Anemia
__ Lymph Node
__ AIDS

ALLERGY/IMMUNOLOGY
__ Hay Fever
__ Dermatitis

SKIN/BREAST
__ Breast Abnormality
__ Change in Skin/Hair

Patient Signature ______________________ *Date* ____________

Reviewed By ______________________ *M.D.* *Date* ____________

NOTE: This is a confidential record of your medical history and will be maintained in this office. The information contained herein will not be released to any person except when you have authorized us to do so.

Beacon Orthopaedics & Sports Medicine, Ltd.

PATIENT REGISTRATION

PATIENT INFORMATION:

Patient Name	Social Security Number
Address	Date of Birth Age Male ☐ Female ☐
City/State/Zip Code	Marital Status M S D W Student YES ☐ NO ☐
Phone: ( )	If Student, Name of School / College :
Emergency Contact Name	Occupation:
Phone Number ( )	Employer:
Name of Primary Care Physician ______	Address
Phone Number ( ) ______	City/State/Zip Code
Name of Referring Physician and/or Hospital	Phone: ( )

IS THIS VISIT DUE TO A MOTOR VEHICLE ACCIDENT? YES ☐ NO☐ DATE OF ACCIDENT: ______

REASON FOR TODAY'S VISIT: ______

______

Date of Injury / Onset: ______ **Specify Site of Injury :** RIGHT☐ LEFT ☐

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE	
Policyholder Name:	Employer *(Policyholder's)*
Address *(if different)*	Address
City/State/Zip Code	City/State/Code
SSN: DOB:	Phone: ( )
NAME OF SECONDARY INSURANCE	
Policyholder Name:	Employer *(Policyholder's)*
Address *(if different)*	Address
City/State/Zip Code	City/State/Code
SSN: DOB:	Phone: ( )

IF PATIENT IS A MINOR

Mother	DOB	Father	DOB
Home Phone	Work Phone	Home Phone	Work Phone
Employer		Employer	
Social Security Number		Social Security Number	

I authorize Beacon Orthopaedics & Sports Medicine, Ltd. to release any information acquired in the course of examination or treatment and allow a photocopy of my signature to be used for specific insurance carriers, third party payers, or others involved in processing and collection of this claim. I hereby authorize payment of benefits due me to be made directly to Beacon Orthopaedics & Sports Medicine, Ltd. I understand that I am financially responsible for all charges.

X ______ Signature Date

X ______ Authorization for Treatment for a Minor Date

**** IF THIS IS A WORK RELATED INJURY, PLEASE TURN OVER THIS FORM AND COMPLETE THE BACK PORTION ****

Beacon Orthopaedics & Sports Medicine, Ltd.

BWC / MCO PATIENT REGISTRATION

** OFFICE POLICY IS TO COPY MCO/BWC CARD AND PRIVATE INSURANCE CARD **

Please provide us with this information

INFORMATION REGARDING PATIENTS INJURED ON THE JOB

BWC/ MCO INFORMATION (Managed Care Organization)	
Date of Injury	Claim #
Employer at Time of Injury	Name of MCO
Employer's Address	MCO Address
City/State/Zip Code	City/State/Code
Phone: ( )	Phone: ( )
Contact Name at Employer	Job Title at Time of Injury

First Date Off Work: ____________________

Allowed Condition / Description of Injury: ____

____

I hereby authorize Beacon Orthopaedics & Sports Medicine, Ltd. to disclose any information regarding this incident to my employer, insurance carrier, BWC and Worker Compensation Representative and hereby release the physicians of Beacon Orthopaedics & Sports Medicine, Ltd. from any liability arising from such disclosure. I fully understand these instructions.

I hereby authorize payment of benefits due me to be made directly to Beacon Orthopaedics & Sports Medicine, Ltd. I understand that I am financially responsible for all charges.

________________________________ ____________________

Signature Date