ACCT#: ____________

AHLFELD SPORTS MEDICINE

PATIENT INFORMATION

NAME: ______________________, ______________________ ______________
LAST FIRST (LEGAL) MIDDLE

ADDRESS: ______________________ ______________________ __________ __________
STREET CITY STATE ZIP

HOME PHONE: ( ) ______________________ CELL PHONE: ( ) ______________________

WORK PHONE: ( ) ______________________ EMAIL ADDRESS FOR PORTAL: ______________________

MARITAL STATUS: ______ GENDER: ______ DATE OF BIRTH: ____________ SOCIAL SECURITY: ____________

EMPLOYER: ______________________ OCUPATION: ______________________

SPOUSE'S NAME: ______________________ DATE OF BIRTH: ______________________

SPOUSE EMPLOYER: ______________________ WORK PHONE: ( ) ______________________

FAMILY PHYSICIAN NAME: ______________________

PHYSICIAN ADDRESS/PHONE: ______________________

HOW WERE YOU REFERRED? ______________________

DO YOU AUTHORIZE AHLFELD SPORTS MEDICINE TO DISCUSS YOUR MEDICAL/BILLING RECORDS WITH ANYONE?

NAME: ______________________ RELATIONSHIP: ______________________

NAME: ______________________ RELATIONSHIP: ______________________

STUDENT INFORMATION SECTION

SCHOOL NAME: ______________________ SPORT(S) ______________________

COACH'S NAME: ______________________ TRAINER'S NAME: ______________________

RESPONSIBLE PARTY FOR MINORS UNDER 18

NAME: ______________________ DATE OF BIRTH: ______________________
LAST FIRST(LEGAL) MIDDLE

ADDRESS: ______________________
STREET CITY STATE ZIP

HOME PHONE: ( ) ______________________ CELL PHONE: ( ) ______________________

RELATIONSHIP TO PATIENT: ______________________

INSURANCE POLICYHOLDER INFORMATION

NAME OF INSURANCE: ______________________ ID#: ______________________

POLICYHOLDER NAME: ______________________ DATE OF BIRTH: ______________________

POLICYHOLDER ADDRESS: ______________________
STREET CITY STATE ZIP

RELATIONSHIP TO PATIENT: ______________________

AHLFELD SPORTS MEDICINE ORTHOPEDIC CENTER
HISTORY AND PHYSICAL

PLEASE ***PRINT*** AND FILL OUT COMPLETELY

ACCT#: ____________

NAME________________________________ DATE______________

AGE________ **HEIGHT**__________ **WEIGHT**__________ **HAND DOMINANCE:** ☐ **LEFT** ☐ **RIGHT**

HISTORY OF INJURY

WHAT IS YOUR CHIEF COMPLAINT TODAY? BODY PART: ______________________

☐ **LEFT** ☐ **RIGHT**

IS THIS THE RESULT OF AN INJURY? ☐ YES ☐ NO *IF YES, DATE OF INJURY/HOW IT OCCURRED: ______________

____

IS THE INJURY WORK RELATED? ☐ YES ☐ NO **MOTOR VEHICLE ACCIDENT?** ☐ YES ☐ NO

IF NO INJURY, HOW LONG HAVE YOU HAD THIS CONDITION? ______________________

RATE YOUR PAIN ON SCALE OF 1 TO 10 (10 BEING MOST PAINFUL): ______________________

DESCRIBE YOUR PAIN: ☐ CONSTANT ☐ OCCASIONAL ☐ SHARP ☐ DULL ☐ ACHING ☐ STABBING ☐ THROBBING

WHAT SYMPTOMS ARE YOU EXPERIENCING? ☐ LOCKING ☐ CATCHING ☐ GIVING AWAY ☐ GRINDING ☐ WEAKNESS

☐ OTHER ____

WHAT, IF ANYTHING, MAKES YOUR SYMPTOMS BETTER? ______________________

WHAT, IF ANYTHING, MAKES YOUR SYMPTOMS WORSE? ______________________

HAVE YOU SEEN ANOTHER PHYSICIAN FOR THIS CONDITION? ☐ YES ☐ NO

IF SO, WHO AND WHEN? ____

WHAT PREVIOUS TREATMENT HAVE YOU TRIED? ☐ PHYSICAL THERAPY ☐ EXERCISE ☐ ACUPUNCTURE

☐ CHIROPRACTIC ☐ INJECTIONS (SPECIFY: ESI, FACET, SACROILIAC, SELECTIVE NERVE ROOT BLOCK, SYNVISC, HYALGAN)

WHAT MEDICATIONS HAVE YOU TRIED?

____

HAVE YOU HAD ANY OF THE FOLLOWING TESTING FOR THIS CONDITION?

IF SO, PLEASE SPECIFY WHEN AND WHERE:

☐ **X-RAYS** ____

☐ **MRI SCAN** ____

☐ **CT SCAN** ____

☐ **EMG/NCV** ____

PLEASE SPECIFY MOST RECENT YEAR THE ITEMS BELOW WERE RECEIVED:

☐ **MAMMOGRAM** ____

☐ **COLONOSCOPY** ____

☐ **INFLUENZA VACCINATION** ______________ ☐ **PNEUMOCOCCAL VACCINATION** ______________

**CONTINUE ON NEXT PAGE

PHARMACY NAME/ADDRESS/PHONE:

____

____

PAST SURGICAL HISTORY

PLEASE CHECK ANY PREVIOUS SURGICAL PROCEDURES:

☐ APPENDECTOMY ☐ HERNIA REPAIR ☐ ARTHROSCOPY (LOWER EXTREMITY) ☐ Right ☐ Left
☐ ARTHROSCOPY (UPPER EXTREMITY) ☐ Right ☐ Left ☐ SPINE/BACK SURGERY ☐ HEART SURGERY
☐ TOTAL JOINT REPLACEMENT ☐ Right ☐ Left LOCATION: ☐ Hip ☐ Knee ☐ Shoulder
☐ OTHER ORTHOPEDIC SURGERY/FRACTURE REPAIR ______________________________

SOCIAL HISTORY

SPECIAL DIET: ☐ YES ☐ NO *ANY RESTRICTIONS? ______________________
TOBACCO USE? ☐ YES ☐ NO *TYPE __________ *FREQUENCY __________
ALCOHOL USE? ☐ YES ☐ NO *FREQUENCY ______________________
DRUG USE? ☐ YES ☐ NO *TYPE __________ * FREQUENCY __________
CAFFEINE USE? ☐ YES ☐ NO *TYPE __________ * FREQUENCY __________
EXERCISE REGULARLY? ☐ YES ☐ NO *TYPE __________ * FREQUENCY __________

ALLERGIES

☐ **NO KNOWN DRUG ALLERGIES** ☐ SULFA ☐ LATEX ☐ PENICILLIN ☐ CODEINE ☐ MORPHINE
☐ OTHER: ____

____

MEDICAL HISTORY

PLEASE CHECK CURRENT OR PREVIOUS MEDICAL CONDITIONS FOR YOU:

☐ ANEMIA ☐ DEPRESSION ☐ HEPATITIS A / B / C ☐ OSTEOPOROSIS ☐ ARTHRITIS ☐ DIABETES ☐ ASTHMA
☐ HIGH BLOOD PRESSURE ☐ RHEUMATOID ARTHRITIS ☐ EMPHYSEMA ☐ HIV ☐ STROKE/SEIZURES
☐ BLOOD CLOTS ☐ HEART DISEASE ☐ THYROID ☐ CANCER ☐ LIVER DISEASE
☐ CHEMICAL DEPENDENCY/ALCOHOLISM ☐ OTHER ______________________
HAVE YOU EVER HAD A BLOOD TRANSFUSION? ☐ YES ☐ NO *IF YES, WHEN? ______________

MEDICATIONS (USE BACK OF SHEET OR GIVE LIST TO RECEPTIONIST TO COPY)

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. INCLUDE ANTIBIOTICS, BLOOD THINNERS, INSULIN, HEART MEDICATIONS, ASPIRIN, AND ANY OVER THE COUNTER, VITAMIN, MINERAL AND HERBAL SUPPLEMENTS.

NAME OF MEDICATION	DOSAGE	FREQUENCY

GASTROINTESTINAL HISTORY

HISTORY OF PEPTIC ULCER DISEASE? ☐ YES ☐ NO *IF YES, WHEN? ______________
HISTORY OF GI/STOMACH BLEED? ☐ YES ☐ NO *IF YES, WHEN? ______________
DO YOU TAKE ANY MEDICATION FOR YOUR STOMACH? (TUMS, ZANTAC, PEPCID, ETC) ☐ YES ☐ NO
*IF SO, LIST DOSAGE AND FREQUENCY ______________________
HAVE YOU EVER TAKEN ANTI-INFLAMMATORY MEDICINE FOR A PERIOD GREATER THAN 30 DAYS? ☐ YES ☐ NO
(*INCLUDING ADVIL, ALEVE, ASPIRIN, OR ANY PRESCRIBED MEDICATIONS SUCH AS CELEBREX, VOLTAREN, ETC.)

**CONTINUE ON NEXT PAGE

FAMILY HISTORY

PLEASE CHECK ANY MEDICAL CONDITIONS OF PARENTS AND CIRCLE WHICH PARENT DIAGNOSED:

☐ BLOOD CLOTS (M or F) ☐ DIABETES (M or F) ☐ HYPERTENSION (M or F) ☐ RHEUMATOID ARTHRITIS (M or F)
☐ HEART DISEASE (M or F) ☐ CANCER (M or F) ☐ OSTEOPOROSIS (M or F) ☐ STROKE/SEIZURES (M or F)

LIST ANY OTHER IMMEDIATE FAMILY MEDICAL CONDITIONS/TYPE OF CANCER: ______________________

REVIEW OF SYSTEMS

CHECK IF YOU HAVE **CURRENT SYMPTOMS OR CURRENT KNOWN MEDICAL PROBLEMS** IN THE FOLLOWING AREAS. PLEASE MARK NONE IF NOT APPLICABLE.

1. **GENERAL** ☐ NONE ☐ WEIGHT LOSS ☐ INSOMNIA ☐ CHRONIC FATIGUE ☐ WEIGHT GAIN ☐ OTHER ______________________
2. **EYES** ☐ NONE ☐ VISION CHANGE ☐ GLASSES/CONTACTS ☐ CATARACTS ☐ GLAUCOMA ☐ PAIN ☐ DISCHARGE ☐ OTHER ______________________
3. **EARS, NOSE, THROAT** ☐ NONE ☐ LOSS OF HEARING ☐ SEASONAL ALLERGIES ☐ SINUS PAIN ☐ RINGING ☐ NOSE BLEEDS ☐ OTHER ______________________
4. **CARDIOVASCULAR** ☐ NONE ☐ CHEST PAIN ☐ EDEMA ☐ HYPERTENSION ☐ PALPITATIONS ☐ FAINTING ☐ HIGH CHOLESTERAL ☐ OTHER ______________________
5. **RESPIRATORY** ☐ NONE ☐ ASTHMA ☐ WHEEZING ☐ FREQUENT COUGH ☐ OTHER ______________________
6. **GASTROINTESTINAL** ☐ NONE ☐ HEARTBURN ☐ INDIGESTION ☐ ACID REFLUX ☐ VOMITING ☐ NAUSEA ☐ ABDOMINAL PAIN ☐ PEPTIC ULCER ☐ GI/STOMACH BLEED ☐ OTHER ______________________
7. **MUSCULOSKELETAL** ☐ NONE ☐ ARTHRITIS ☐ MUSCLE WEAKNESS ☐ JOINT PAIN ☐ BACK PAIN ☐ OTHER ______________________
8. **SKIN** ☐ NONE ☐ RASH ☐ SKIN ULCER ☐ SCARS ☐ OTHER ______________________
9. **NEUROLOGICAL** ☐ NONE ☐ HEADACHES ☐ SEIZURES ☐ NUMBNESS ☐ DIZZINESS ☐ OTHER ______________________
10. **PSYCHIATRIC** ☐ NONE ☐ DEPRESSION ☐ CRYING ☐ ANXIETY ☐ MOOD SWING ☐ OTHER ______________________
11. **ENDOCRINE** ☐ NONE ☐ DIABETES ☐ HYPOTHYROID ☐ HYPERTHYROID ☐ HOT FLASHES ☐ OTHER ______________________
12. **HEMATOLOGY** ☐ NONE ☐ EASY BRUISING ☐ BLEEDING ☐ ANEMIA ☐ OTHER ______________________
13. **GENITOURINARY** ☐ NONE ☐ FREQUENCY ☐ HESITANCY ☐ FLANK PAIN ☐ PAINFUL URINATION ☐ BLOOD IN URINE ☐ OTHER ______________________

PATIENT/GUARDIAN SIGNATURE ______________________

DATE ______________________

CONSENT AND ASSIGNMENT

I hereby authorize direct payment of medical benefits to Steven K. Ahlfeld, M.D. for services rendered to myself or my dependent (s). I also authorize Steven K. Ahlfeld, M.D. to release any medical or incidental information that may be necessary for medical care to my Insurance Carrier. I also hereby authorize and consent to the giving of all treatments, examinations, medications and any procedures deemed necessary by Steven K. Ahlfeld, M.D. that may be considered necessary or advisable for diagnosis or treatment.

Responsible Party Name: ____

Please print

Signature: ______________________________________ Date: ____________________

FINANCIAL RESPONSIBILITY

I understand that payment for medical services rendered is to be paid at the time of service for all non-contracted insurance plans. These include but are not limited to traditional insurance plans, auto accident liability, non-authorized Worker's Compensations claims as well as non-insured's.

If I am covered under an insurance plan that Dr. Steven K. Ahlfeld has contract with, a claim will be filed on my behalf and I will be responsible for any deductible, co-pay amounts and/or any non-covered services which could include but is not limited to any services that my insurance company deems not medically necessary. I agree that any up front office co-pays will be paid at that time of service. Furthermore, if I am covered under an insurance plan that requires prior authorization before seeing a specialist, I have obtained this prior authorization. If this has not been obtained, I understand that I will be responsible for payment of all fees at the time of service.

I also understand that if I have not met my deductible for any calendar year that I will be responsible to pay any fees up to my policy amount at the time of service.

In cases of Divorce, it is the FULL RESPONSIBILITY of the parent who brings their child in and signs for authorization of treatment for full payment of services.

In the event that any unpaid balance is referred for collections, I agree to be responsible for any and all collections fees, attorney fees and court costs if necessary.

REPSONSIBLE PARTY NAME: ____

Please Print

RESPONSIBLE PARTY SIGNATURE: ______________________________ DATE: ____________

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

Your have the right to inspect and copy your protected health information. Under federal law, however, your may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state that specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before JANUARY 1, 2011.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name________________ Signature________________ Date________