Andrew L. Whaley, M.D.
Diplomate, American Board of Orthopaedic Surgeons
Subspeciality Certification in Orthopaedic Sports Medicine

Revised 04/2025

Patient Information

Patient's Name: (Last)_____ (First)_____

(Middle Name) _____

Female / Male Marital Status: Married / Single / Divorced Date of Birth: _____/_____/_____

Social Security Number:_____ - _____ - _____ Email address: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____

Cell Phone: _____ - _____ - _____ Home Phone: _____- _____- _____

Employer: _____ Occupation: _____

Emergency Contact's Name: _____ Phone Number: _____-_____-_____

Relationship to Patient: _____

How were you referred to us? _____

Responsible Party's Information (Person responsible for payments. Leave blank if same as patient.)

Name: (Last)_____ (First) _____ (Middle) _____

Relationship to Patient: _____ Female / Male

Phone Number: _____ - _____ - _____ Social Security Number: _____-_____-_____

Street Address:_____ City: _____

State: _____ Zip Code: _____ Date of Birth: _____/_____/_____

Primary Insurance Information

Name of Insurance: _____ Phone Number: _____-_____-_____

Policy Number: _____ Group Number: _____

Name of Insured: _____ Relationship to Patient: _____

Insured Social Security Number: _____-_____-_____ Insured Date of Birth: _____/_____/_____

Secondary Insurance Information

Name of Insurance: _____ Phone Number: _____-_____-_____

Policy Number: _____Group Number: _____

Name of Insured: _____ Relationship to Patient: _____

Insured Social Security Number: _____-_____-_____ Insured Date of Birth: _____/_____/_____

I agree that the information applied in this form is accurate and up to date to the best of my knowledge.

Patient's Signature (or Responsible Party) : _____Today's Date: _____

Consent for Purpose of Treatment, Payment, Healthcare Operations and Notice of Privacy Practices

I consent to the use or disclosure of my protected health information by Andrew L. Whaley, MD, PA, hereby referred to as Andrew L. Whaley, MD, PA, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Andrew L. Whaley, MD, PA. I understand that diagnosis or treatment of me by **Andrew L. Whaley, M.D., Collin Krasowski, PA-C and/or other providers that are employed or contracted with** Andrew L. Whaley, MD, PA may be conditioned upon my consent as evidence by my signature on this document. I understand that **Andrew L. Whaley, M.D. and/or other providers that are employed or contracted with** Andrew L. Whaley, MD, PA may provide care to me in facilities in which they may have a financial interest.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practices. Andrew L. Whaley, MD, PA is not required to agree to the restrictions that I may request. However, if Andrew L. Whaley, MD, PA agrees to a restriction that I request, the restriction is binding on Andrew L. Whaley, MD, PA.

_____.
(Write your name here)

I have the right to revoke this consent, in writing, at any time, except to the extent that **Andrew L. Whaley, M.D., Collin Krasowski, PA-C and/or other providers that are employed or contracted with** Andrew L. Whaley, MD, PA or Andrew L. Whaley, MD, PA has taken action in reliance on the consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Andrew L. Whaley, MD, PA Notice of Privacy Practices prior to signing this document. The Andrew L. Whaley, MD, PA Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, 3rd party collections, or in the performance of health care operations of the Andrew L. Whaley, MD, PA The Notice of Privacy Practices for Andrew L. Whaley, MD, PA is also available at the front desk of each clinic and on the Andrew L. Whaley, MD, PA website at **www.ossmsa.com.** This Notice of Privacy Practices also describes my rights and the Andrew L. Whaley, MD, PA, duties with respect to my protected health information.

ANDREW L. WHALEY, MD, PA reserves the right to change the privacy practices described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing the Andrew L. Whaley, MD, PA website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

Release of Protected Health Information: I authorize Andrew L. Whaley, MD, Collin Krasowski, PA-C and/or other providers and staff that are employed or contracted with Andrew L. Whaley, MD, PA to discuss and/or release my protected health information, including labs and test results, diagnosis, treatments discussed and billing information to the following persons:

Name_____ Relationship to Patient _____ Phone #_____

Name_____ Relationship to Patient _____ Phone #_____

Name_____ Relationship to Patient _____ Phone #_____

☐ Do not release my information to family members/friends.

Authorization to Release Information: I authorize Andrew L. Whaley, MD, Collin Krasowski, PA-C and/or other providers and staff that are employed or contracted with Andrew L. Whaley, MD, PA to release any healthcare information as necessary to A) obtain a payment from my health insurance company for my healthcare, B) to conduct utilization review, peer review, and quality assurance, and C) to other healthcare providers that will assist with my care. I understand that this information will identify me and relate to my history, diagnosis, treatment or prognosis. It may also include psychiatric, alcohol abuse, drug abuse, specific laboratory results of HIV or the diagnosis of AIDS. I understand that in the event of a healthcare worker being exposed to my blood or bodily fluids, my blood may be tested for the HIV antibody and other communicable diseases.

Financial Authorizations: I authorize all payers to pay directly Orthopaedic Surgery and Sports Medicine of San Antonio ("OSSMSA"), Andrew L. Whaley, MD, PA, Andrew L. Whaley, MD, Collin Krasowski, PA-C and/or other providers that are employed or contracted with Andrew L. Whaley, MD, PA for services provided. I assign to OSSMSA, Andrew L. Whaley, MD, PA, Andrew L. Whaley, MD, Collin Krasowski, PA-C and/or other providers that are employed or contracted with Andrew L. Whaley, MD, PA my right to receive payment from third party payers which include anyone from whom benefits are, or may become payable to me for services provided.

Financial Responsibilities: I understand my responsibility to pay all charges that result from the care provided to me and not paid by my insurance company. I understand my responsibility to submit accurate information on all dates of service and to comply with all requests of my insurance company within a timely manner to ensure payment is made. Any patient balance that is older than 90 days and has received three (3) statement requesting payment, in which payment or a payment arrangement has not been established, may qualify for collections. I understand that if I am covered by Medicare or Medicaid, my obligation under this section may be limited by law.

Sunshine ACT Disclosure: In compliance with the Sunshine Act, a provision of the Affordable Care Act, we wish to disclose that our office occasionally receives food and beverages, sample drugs and patient coupons, and promotional material from pharmaceutical vendors and/or manufactures in conjunction with product education. We do not receive direct financial compensation from any of our vendors.

Telephone Calls: Telephone questions may be referred to one of our experienced medical assistants in order to obtain answers/guidance from one of our medical providers. Messages may possibly not be returned during active clinic hours as the medical staff is treating patients. Messages are returned first thing in the morning, before lunch break, and after evening clinic. Do not leave urgent or emergency questions on the voicemail. Please seek immediate medical care by dialing 911 for emergencies.

Forms/Fees: I understand there is a $50 charge for any type of patient forms that need to be completed by our office. This includes, FMLA, Short-Term Disability, Physician Statement Forms etc. Please allow 10 business days after the paperwork is delivered to our office for the forms to be available for pick up. For expedited service for a completion of forms within 5 business days, there will be a charge of $100. There also may be a $50 after hours call charge for phone consultations with the on-call provider for calls deemed non-emergent.

No Show/Late Appointment Policy: I understand that 24 hours' notice is required for appointment cancellations and that cancellations can and must be left on voicemail if after hours. Without 24 hours' notice, I understand and agree to a $25 no show fee. All no-show fees are to be collected prior to the next scheduled appointment or before services are rendered. After 3 No Shows on record, we reserve the right to conclude our relationship for noncompliance of stated office policy. If you are more than 15 minutes late for your scheduled appointment, you will need to reschedule your appointment or, if feasible, wait to be worked back in. The practice runs on a tight schedule in order to provide the best care for all in a timely manner.

What if my child needs to see the provider: A parent or legal guardian must accompany minor patients on all office visits. This accompanying adult is responsible for payment on the account.

Patient/Legally Responsible Person (signature required): By signing, you certify that this form has been fully explained to you, that you have been given the opportunity to ask questions and that you fully understand its contents.

Patient's signature_____ Date_____

Patient's name_____ Revised 04/2025

Patient's Name: (Last) _____ (First) _____ DOB_____

Who completed this form? (please circle) Patient Spouse/Family Member Guardian

If not patient, please write name of person completing form: _____

A) HEALTHCARE PROVIDER INFORMATION & AUTHORIZATION TO RELEASE INFORMATION

Primary Care Physician's Name: _____ NONE

Do you wish us to forward information from our clinic visits to your PCP? ☐ Yes ☐ No

Phone: _____

Address: _____

City/State/Zip: _____

Fax Number: _____

Preferred Pharmacy:_____ Phone #: _____

Address: _____

B) MEDICAL HISTORY

Allergies (seasonal)	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	If yes, what type? _____		
Anxiety	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	High cholesterol	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No
Autoimmune disorder	☐ Yes	☐ No	Kidney stones	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No	Liver problems	☐ Yes	☐ No
Bleeding disorder	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Blood clots (DVT/PE	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Stomach reflux (GERD)	☐ Yes	☐ No
If yes, where? _____			Seizures	☐ Yes	☐ No
Depressi	☐ Yes	☐ No	Sleep apnea	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Splenic problems	☐ Yes	☐ No
If yes, where? _____			Stroke/TIA	☐ Yes	☐ No
Emphysema/COPD/ lung disease	☐ Yes	☐ No	Stomach ulcers	☐ Yes	☐ No
Fractures	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No
If yes, what type? _____			Urinary tract infections	☐ Yes	☐ No
Gout	☐ Yes	☐ No			
Migraines	☐ Yes	☐ No	Other medical history? _____		
Hearing loss/ ear problems	☐ Yes	☐ No	_____		
Heart arrhythmia (abnormal rate)	☐ Yes	☐ No	**Females:**		
Heart attack (MI)	☐ Yes	☐ No	Endometriosis	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No	_____		
If yes, what type?_____			**Males:**		
			Prostate enlargement	☐ Yes	☐ No

Have you ever been evaluated by a cardiologist? ☐ Yes ☐ No

Patient's name: (Last) _____ (First) _____

C) SURGICAL HISTORY Have you had any of the following?

Abdominal surgery ☐ Yes ☐ No
Appendectomy ☐ Yes ☐ No
Brain surgery ☐ Yes ☐ No
Back surgery ☐ Yes ☐ No
Bladder surgery ☐ Yes ☐ No
Bone surgery ☐ Yes ☐ No
Cosmetic surgery ☐ Yes ☐ No
If yes, what type? _____
Eye surgery ☐ Yes ☐ No
If yes, what type? _____
Gallbladder removal ☐ Yes ☐ No
Heart surgery ☐ Yes ☐ No
If yes, what type? _____
Hernia repair ☐ Yes ☐ No
If yes, what type? _____

Nasal surgery ☐ Yes ☐ No
Thyroid surgery ☐ Yes ☐ No
If yes, what type? _____
Tonsillectomy ☐ Yes ☐ No

Females:

Breast surgery ☐ Yes ☐ No
If yes, what type?_____
C- Section ☐ Yes ☐ No
Hysterectomy ☐ Yes ☐ No
Tubal ligation ☐ Yes ☐ No

Males:

Prostate surgery ☐ Yes ☐ No
Vasectomy ☐ Yes ☐ No

Other surgical history? _____

D) ALLERGIES Name of medication Reaction

Are you allergic to any medication? ☐ Yes ☐ No _____
_____

Have you had an allergic reaction to any of the following? (circle all that apply)

Iodine/X-ray contrast dye Latex Adhesive Tape Influenza Vaccine Other:_____

E) MEDICATIONS

Do you currently take any prescribed medications? ☐ Yes ☐ No
Do you take any over-the-counter supplements? ☐ Yes ☐ No

Medication Name	Dose	How often taken

Medication Name	Dose	How often taken

If more medicines, please attach another sheet

F) SOCIAL HISTORY Please circle all that apply

Current employment status: Employed Unemployed Retired Student Other

Living Arrangement: With family Alone With Friends Other

Are you disabled? ☐ Yes ☐ No

Patient's name (Last) _____ First Name _____

F) SOCIAL HISTORY CONTINUED Andrew L. Whaley, MD Page 6

Current Alcohol Use ☐ Yes ☐ No If yes, # of drinks per week _____ updated 04/25

Current Drug Use ☐ Yes ☐ No Previously, but quit (date)_____

Do you exercise? ☐ Yes ☐ No If yes, how often? _____

G) FAMILY HISTORY □ Unknown/Adopted

	Mother	Father
Heart Disease	□	□
Cancer	□	□
High Blood Pressure	□	□
High Cholesterol	□	□
Stroke (CVA/TIA)	□	□
Bleeding Disorders	□	□
Adverse Reaction to Anesthesia	□	□
If Deceased, at what age?		

H) REVIEW OF MEDICAL HISTORY Please circle symptoms that apply to you.

EAR, NOSE, THROAT	NONE	Snoring	Difficulty swallowing	Sinus Problems		
DERMATOLOGY	NONE	Rash	Excessive scarring	Keloid Formation		
RESPIRATORY	NONE	Asthma	Shortness of breath	Wheezing	Coughing up blood	
CARDIOVASCULAR	NONE	Chest pain	Chest pain w/exertion	Palpitations	Irregular heart beat	
		High BP	Heart murmur	Rapid heart beat	Pain in calves when walking	
GASTROINTESTINAL	NONE	Nausea	Vomiting	Heartburn	Abdominal Pain	
HEMATOLOGY	NONE	Night sweats	Bleeding problems	Prior Transfusion	Prolonged bleeding	Anemia
NEUROLOGY	NONE	Weakness	Gait difficulties	Tingling/numbness	Stroke	
		Restless legs	Peripheral neuropathy			
MUSCULOSKELETAL	NONE	Joint pain	Joint stiffness	Joint swelling	Joint redness	
		Back pain	Back stiffness	Sciatica	Muscle pain	Muscle spasms
PSYCHOLOGY	NONE	Depression	Substance abuse	Panic attacks	Significant Stress	Anxiety
MISC HEALTH	NONE	Fever	Weight Gain	Weight Loss	Insomnia	

I) OSTEOARTHRITIS: 21 years and Older

Have you been formally diagnosed with Osteoarthritis by a medical provider? ☐ YES ☐ NO

J) OSTEOPOROSIS: 50 years and Older

Have you had a central dual-energy x-ray, also known as a DXA, to check for Osteoporosis? ☐ YES ☐ NO

Have you been diagnosed with Osteoporosis in the last 12 months? ☐ YES ☐ NO

If yes, are you currently taking medication to treat your Osteoporosis? ☐ YES ☐ NO

Have you had a DXA scan to check bone mineral density? ☐ YES ☐ NO

Have you had or do you have a fracture? ☐ YES ☐ NO

If yes, have you received Rx medication to treat Osteoporosis? ☐ YES ☐ NO

K) Advance Directives: Patients 65 Years or Older

Advance directives are legal documents that allow you to communicate your medical wishes to others when you are unable to do so yourself. Types of advance directives are living will, medical power of attorney or DNR (Do not resuscitate).

Do you currently have any of these Advance Directives?

☐ Yes ☐ No ☐ Choose not to answer

If **yes**, in your legal documents, do you a health care decision maker (or emergency contact) assigned?

☐ Yes ☐ No ☐ Choose not to answer

Optional - If you would like to name this person, please place the name here

_____

L) Fall Risk Assessment: Patients 65 Years or older

Please select one answer to the following regarding your history of falling.

_____ No falls in the past year
_____ One fall **with** injury in the past year
_____ Two or more falls **with** injury in the past year
_____ One fall **without** injury in the past year
_____ Two or more falls **without** injury in the past year

M) Tobacco Screening:

Current tobacco use: ☐ Yes ☐ No

If yes, packs per day _____ Years use_____

If no, is your home tobacco and smoke free?

☐ Yes ☐ No

Patient's Signature: _____ Date:_____

Provider's Signature:_____ Date: _____