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

Revised 6/2023

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.)

e: (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 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____

Andrew L. Whaley, MD

updated 7/23

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

Condition	Yes	No
Allergies (seasonal)	☐ Yes	☐ No
Atherosclerosis (clogged arteries)	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Autoimmune disorder	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No
Bleeding disorder	☐ Yes	☐ No
Blood clots (DVT/PE)	☐ Yes	☐ No
If yes, where? ____________		
Cancer	☐ Yes	☐ No
If yes, where? ____________		
Dementia	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
If yes, what type? ____________		
Emphysema/ COPD/ lung disease	☐ Yes	☐ No
Eye disease	☐ Yes	☐ No
If yes, what type?____________		
Fractures	☐ Yes	☐ No
If yes, where? ____________		
Gout	☐ Yes	☐ No
Migraines	☐ Yes	☐ No
Hearing loss/ ear problems	☐ Yes	☐ No
Heart arrhythmia (abnormal rate)	☐ Yes	☐ No
Heart attack (MI)	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
If yes, what type? ____________		
Have you ever been evaluated by a cardioligist?	☐ Yes	☐ No

Condition	Yes	No
Hepatitis	☐ Yes	☐ No
If yes, what type? ____________		
Hernia	☐ Yes	☐ No
If yes, what type? ____________		
High blood pressure	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No
Kidney stones	☐ Yes	☐ No
Liver problems	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Stomach reflux (GERD)	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Sleep apnea	☐ Yes	☐ No
Splenic problems	☐ Yes	☐ No
Stroke/TIA	☐ Yes	☐ No
Stomach ulcers	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
If yes, what type?____________		
Tuberculosis	☐ Yes	☐ No
Urinary tract infections	☐ Yes	☐ No

Other medical history? ______________________________
____

Females:

Condition	Yes	No
Endometriosis	☐ Yes	☐ No
Polycystic ovarian syndrome	☐ Yes	☐ No

Males:

Condition	Yes	No
Prostate enlargement	☐ 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
If yes, what type? ________________

Bladder surgery ☐ Yes ☐ No

Bone surgery ☐ Yes ☐ No
If yes, what type?________________

Bowel 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 biopsy ☐ Yes ☐ No
If yes, what type?_____________________

Breast surgery ☐ Yes ☐ No
If yes, what type?_____________________

C- Section ☐ Yes ☐ No

Hysterectomy ☐ Yes ☐ No

Tubal ligation ☐ Yes ☐ No

Ovarian cyst removal ☐ Yes ☐ No

Males:

Prostate surgery ☐ Yes ☐ No

Vasectomy ☐ Yes ☐ No

Other surgical history? ____

D. ALLERGIES

Are you allergic to any medication? ☐ Yes ☐ No

Name of medication Reaction
____
____

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

Current tobacco use: ☐ Yes ☐ No If yes, packs per day:__________ Years use:___________
If no, is your home tobacco and smoke-free? ☐ Yes ☐ No

Current alcohol use: ☐ Yes ☐ No If yes, # of drinks per week: ___________________________

Current drug use: ☐ Yes ☐ No Previously, but quit (date): _________________________

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

Do you follow a special diet? ☐ Yes ☐ No If so, what diet? __________________________________

G. FAMILY HISTORY ☐ Unknown / Adopted

	Mother	Father	Sisters	Brothers	Mother's mother	Mother's father	Father's mother	Father's father
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Stroke (CVA/TIA)	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐	☐	☐	☐	☐
Adverse Reaction to Anesthesi	☐	☐	☐	☐	☐	☐	☐	☐
If Deceased, at what age?								

H. REVIEW OF SYSTEMS

Constitutional	NONE	Fever	Weight Gain	Weight Loss	Insomnia	
Ear, Nose, Thoat	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

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 or do you have a fracture?

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

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

K. OSTEOARTHRITIS: 21 years and Older

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

L. FALL HISTORY: 65 years and Older

Do you have a history of falling? ☐ YES ☐ NO

If you are a returning patient, have you fallen since your last visit? ☐ YES ☐ NO

Two or more falls in the past year? ☐ YES ☐ NO

Fall with an injury in the past year? ☐ YES ☐ NO

Patient's Signature: ______________________________ Today's Date: ______________

Provider's Signature: ______________________________ Date: ______________