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

Revised 1/2020

Patient Information

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

Female / Male Marital Satus: Married / Single / Divorced / Widowed / Legally Separated / Other_____

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

Address:_____ City: _____ State: _____ ZIP Code _____

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

Work: _____ - _____ - _____ Primary Contact Preference: cell home work

Email Address:_____

Employment Status: Full-Time Student / Part-Time Student / Self-Employed / Unemployed / Retired / Employed

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

Email Address:_____ Date of Birth:____ /____ /____

Social Security Number: _____ - _____ - _____

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

Work: _____ - _____ - _____

Street Address:_____ City: _____ State: _____ Zip Code: _____

Employment Status: Full-Time Student / Part-Time Student / Self-Employed / Unemployed / Retired / Employed

Employer:_____ Occupation:_____

Primary Insurance Information

Name of Insurance: _____ Phone Number:_____-_____-_____ Effective Date: _____ /_____ /_____

Policy Number: _____ Group ID _____ Co-Pay Amount: $_____

Name of Insured: _____ Relationship to Patient: _____ Insured's D.O.B.: _____ /_____ /_____

Is the insurance through an employer? Yes / No Insured's Social Security Number: _____- _____ - _____

Secondary Insurance Information

Name of Insurance: _____ Phone Number: _____-_____-_____ Effective Date: _____ /_____ /_____

Policy Number: _____ Group ID _____ Co-Pay Amount: $_____

Name of Insured: _____ Relationship to Patient: _____ Insured's D.O.B.: _____ /_____ /_____

Is the insurance through an employer? Yes / No Insured's Social Security Number: _____ - _____ - _____

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., Michael E. Rodriguez, PA-C, MBA 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 including Advanced Surgery Center of San Antonio.

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., Michael E. Rodriguez, PA-C, MBA and /or other providers that are employed or contacted 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, Michael E. Rodriguez, PA-C, MBA and their staff 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, and/or Michael E. Rodriguez, PA-C, MBA 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, that 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, and/or Michael E. Rodriguez, PA-C, MBA for services provided. I assign to OSSMSA, Andrew L. Whaley, MD PA, Andrew L. Whaley, MD, and/or Michael E. Rodriguez, PA-C, MBA 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 1/2020

Name: _____ 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: _____ NONE ☐

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

Name/Title: _____

Phone: _____

Address: _____

City/State/Zip: _____

Preferred Pharmacy: _____ Phone #: _____

Address: _____

B. MEDICAL HISTORY

Allergies (seasonal)	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Atherosclerosis (clogged arteries)	☐ Yes	☐ No	If yes, what type?	_____	
Anemia	☐ Yes	☐ No	Hernia	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	If yes, what type?	_____	
Arthritis	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	High cholesterol	☐ Yes	☐ No
Autoimmune disorder	☐ Yes	☐ No	HIV	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No	Incontinence	☐ Yes	☐ No
Bleeding disorder	☐ Yes	☐ No	Insomnia	☐ Yes	☐ No
Blood clots (DVT/PE)	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No
If yes, where?	_____		Kidney stones	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Liver problems	☐ Yes	☐ No
If yes, where?	_____		Osteoporosis	☐ Yes	☐ No
Dementia	☐ Yes	☐ No	Pacemaker/AICD	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Stomach reflux (GERD)	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
If yes, what type?	_____		Sleep apnea	☐ Yes	☐ No
Emphysema/ COPD/ lung disease	☐ Yes	☐ No	Splenic problems	☐ Yes	☐ No
Eye disease	☐ Yes	☐ No	Sexual transmitted disease	☐ Yes	☐ No
If yes, what type?	_____		Stroke/TIA	☐ Yes	☐ No
Fractures	☐ Yes	☐ No	Stomach ulcers	☐ Yes	☐ No
If yes, where?	_____		Thyroid disease	☐ Yes	☐ No
Gout	☐ Yes	☐ No	If yes, what type?	_____	
Migraines	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Hearing loss/ ear problems	☐ Yes	☐ No	Urinary tract infections	☐ Yes	☐ No
Heart arrhythmia (abnormal rate)	☐ Yes	☐ No	Other medical history?	_____	
Heart attack (MI)	☐ Yes	☐ No	_____		
Heart disease	☐ Yes	☐ No	**Females:**		
If yes, what type?	_____		Endometriosis	☐ Yes	☐ No
Have you ever been evaluated by a cardiologist?	☐ Yes	☐ No	Polycystic ovarian syndrome	☐ Yes	☐ No
			Males:		
			Prostate enlargement	☐ Yes	☐ No

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
Ovarian cyst removal ☐ Yes ☐ No
Tubal ligation ☐ Yes ☐ No

Males:

Prostate surgery ☐ Yes ☐ No
Vasectomy ☐ Yes ☐ No

Other surgical history? _____

D. ALLERGIES

Are you allergic to any medication? ☐ Yes ☐ No

Do you have any food allergies? ☐ Yes ☐ No

Name	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	Strength & Dose	Frequency

If more, please attach another sheet

F. SOCIAL HISTORY

Please circle all that apply:

Marital Status: Married Divorced Widowed Single
Change in marital status in past year? ☐ Yes ☐ No
Occupation: _____
Current employment status: Employed Unemployed Retired Other (homemaker, student, etc)
Are you disabled? ☐ Yes ☐ No
Current tobacco use: ☐ Yes ☐ No ☐ Previously but quit (date): _____
If yes: Servings per day _____ Days per week _____ Years used _____
Type: Cigarettes Cigars Chewing Pipe E-cigarettes
If no, if your home tobacco- and smoke-free? ☐ Yes ☐ No
Current alcohol use: ☐ Yes ☐ No If yes: # drinks/week _____ Type _____
Current drug use: ☐ Yes ☐ No ☐ Previously, but quit (date): _____
Have you ever had a blood transfusion? Yes No
Do you exercise? ☐ Yes ☐ No If yes, how often? _____ Type? _____

G. FAMILY HISTORY ☐ Unknown / Adopted

Family Member	Alive	Deceased (age at death)	Breast Cancer	Bleeding Problems	Colon cancer	COPD	Diabetes	Heart attack	Heart failure	High cholesterol	High blood pressure	Kidney disease	Lung cancer	Lupus/ Rheum arthritis	Mental illness	Prostate cancer	Stroke	Thyroid disease	Other
Daughter(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Son(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mat. grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pat. grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other relatives	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

H. REVIEW OF SYSTEMS Circle each symptom you have experienced in the <u>past several months</u>:

Circle NONE if you have not had any symptoms.

Const	NONE	Fatigue	Weight gain	Weight loss	Loss of appetite	Insomnia Fever
HENT	NONE	Headaches	Sinus problems	Snoring	Diminished hearing	Ringing in ears
		Sore throat	Dry Mouth	Cough	Hoarseness	Difficulty swallowing
Ophtho	NONE	Vision loss	Blurry vision	Eye pain	Flashes/floaters	Double vision
Allergy	NONE	Runny nose	Itchy eyes	Ear fullness	Sinus congestion	Hives
Derm	NONE	Change in mole	Rash	Skin sores	Excessive scarring	Acne
Resp.	NONE	Shortness of breath	Asthma	Wheezing	Cough up blood	TB exposure
Cardio	NONE	Chest pain	Chest pain w/exertion	Palpitations	Irregular heart beat	Rapid heart beat
		High BP	Heart murmur	Dizziness	Pre-syncope/Syncope	Shortness of breath at night
		Difficulty lying flat	Dyspnea on exertion	Weight gain	Swelling in hands/feet	Pain in calves when walking
GI	NONE	Abdominal pain	Nausea	Vomiting	Difficulty swallowing	Heartburn
		Diarrhea	Constipation	Blood in stool	Change in bowel habits	Decreased appetite
Endo	NONE	Hair loss	Hot flashes	Fatigue	Heat intolerance	Cold intolerance
		Irregular menses	Difficulty sleeping	Excessive thirst	Excessive sweating	Thyroid problem
Heme/Lymph	NONE	Night sweats	Bleeding problem	Transfusion	Prolonged bleeding	Family hx bleeding problem
		Anemia	Enlarged gland	Breast lump	Easy bruising	Weight changes
Urology	NONE	Frequent urination	Urinary urgency	Nocturia	Painful urination	Urinary incontinence
		Recurrent UTI	Incomplete voiding	Impotence	Blood in urine	Groin mass
Neuro	NONE	Weakness	Gait difficulties	Memory loss	Tremor	Slurred speech
		Tingling/numbness	Seizure disorder	Headaches	Restless legs	Peripheral neuropathy
MSK	NONE	Joint pain	Joint stiffness	Joint swelling	Joint redness	Difficulty moving arm/leg
		Back pain	Back stiffness	Sciatica	Muscle pain	Muscle spasm
Psych	NONE	Depressed mood	Anxiety	Panic attacks	Eating disorder	Significant stress
		Sleep disturbance	Substance abuse	Mental abuse	Physical abuse	Suicidal ideation

J. OSTEOPOROSIS: (Younger than 50, do not need to complete) **BOLD is for Office use only.**

Have you had a central dual-energy x-ray, also known as a DXA, to check for osteoporosis?	NO	**(G8400)**	YES	**(G8399)**
Have you been diagnosed with Osteoporosis in the last 12 months?	NO		YES	
If yes, are you currently taking medication to treat your Osteoporosis?	NO	**(4005F/8P)**	YES	**(4005F)**
Have you had or do you have a fracture?				
If yes, have you received Rx medication to treat Osteoporosis?	NO	**(G8635)**	YES	**(G8633)**
Have you had a DXA scan to check bone mineral density?	NO	**(3095F/8P)**	YES	**(3095F)**

K. OSTEOARTHRITIS: 21 and Older

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

L. FALL HISTORY: 65 and Older

Do you have a history of falling?	NO		YES	
If you are a returning patient, have you fallen since your last visit?	NO		YES	
Two or more falls in the past year?	NO		YES	
Fall with an injury in the past year?	NO		YES	

Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____