

ADULT Patient Questionnaire

 <p>18411 Clark St, Ste 302 Tarzana, CA 91356</p>	Patient Information		
	FIRST AND LAST NAME	Male Female	DATE OF BIRTH
	HOME ADDRESS	CITY	STATE AND ZIP
	EMAIL ADDRESS (Used for appointment reminders)		
	HOME PHONE	CELL PHONE	
	PRIMARY PHYSICIAN	CITY	PHONE
PREFERRED PHARMACY	CITY	PHONE	
EMERGENCY CONTACT FIRST AND LAST NAME	RELATION	EMAIL	CELL PHONE #
HOW DID YOU HEAR ABOUT US? <input type="checkbox"/> yelp <input type="checkbox"/> Online *Source: _____ <input type="checkbox"/> Physician : _____ <input type="checkbox"/> Friend: _____ <input type="checkbox"/> Family Member: _____ <input type="checkbox"/> Other: _____			
INSURANCE CARRIER:	BILLING ADDRESS IF DIFFERENT FROM ABOVE		
SUBSCRIBERS NAME AND DOB			
Patient Acknowledgement of PCSM Education Site <p>Here at Primary Care Sports Medicine, our doctors have a passion of teaching and instructing future doctors and other healthcare professionals by allowing them to participate in rotations and internships here in our clinic. This allows medical residents/students to get firsthand experience in the area of non-surgical sports medicine.</p> <p>Please note that your care plan will not be dictated by the resident's/student's involvement and you will always be evaluated by the provider with whom you are scheduled. Your willingness to contribute to the learning of these students/residents much appreciated and is a vital part of the experience of our future doctors and health professionals.</p> <p align="center">*PLEASE READ CAREFULLY AND CHOOSE <u>ONE OPTION ONLY</u>*</p> <p>While providing this service is important to us, your comfort is more important. Please indicate below your preference.</p> <p>___ I AM comfortable with having students/residents <i>Observe, ask questions about my injury/nature my visit, take my vitals and perform a brief physical exam (only by a resident physician)</i> during my visit to further their learning.</p> <p>___ I AM NOT comfortable with having students/residents present during my visit.</p> <p>___ I AM comfortable having students/residents <u>OBSERVE ONLY</u>.</p> <p align="center">Signature: _____ Date: _____</p>			



Please complete the following Medical Questionnaire

Review of Systems: (Please check those that apply)

Constitutional:

- | | | |
|--------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Chills | <input type="checkbox"/> Decline in Health | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Weakness | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Weight Loss | | |

Head:

- | | | |
|------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain | <input type="checkbox"/> Sweats |

Eyes:

- | | | |
|--|---|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Discharge | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Eyeglass Use | <input type="checkbox"/> Pain with Light |
| <input type="checkbox"/> Recent Injury | <input type="checkbox"/> Unusual Sensations | <input type="checkbox"/> Vision Loss |

ENT:

- | | | |
|--|--|---|
| <input type="checkbox"/> Discharge (nose) | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Nasal Obstruction | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Discharge (ears) | <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Pain (ears) | <input type="checkbox"/> Ringing in Ears | |

Respiratory:

- | | | |
|--|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Positive TB Test | <input type="checkbox"/> Recent Chest X-Ray |
| <input type="checkbox"/> Short of Breath | <input type="checkbox"/> Sputum | <input type="checkbox"/> Tuberculosis |

Cardiovascular:

- | | | |
|---|---|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Extremity(s) Cool |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> History of Heart Attack |
| <input type="checkbox"/> Short of Breath-Exertion | <input type="checkbox"/> Short of Breath-Lying Flat | <input type="checkbox"/> Thrombophlebitis |

Gastrointestinal:

- | | | |
|---|---|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Excessive Hunger | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |

Musculoskeletal:

- | | | |
|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Deformities | <input type="checkbox"/> Joint Stiffness |
| <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Muscle Stiffness | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Restricted Motion | <input type="checkbox"/> Weakness | |

Skin:

- | | | |
|---------------------------------|----------------------------------|--|
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Itching | <input type="checkbox"/> Easy Bruisability |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Lumps | <input type="checkbox"/> Skin Color Change |

Neurological:

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Blackouts | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Strokes | <input type="checkbox"/> Tingling | <input type="checkbox"/> Unsteady Gait |

Patient Name: _____ Patient Date of Birth: _____ Today's Date: _____

HEIGHT: _____ WEIGHT: _____

Allergies: List all Allergies and known reactions

Current Medications: List all Medications with dosage

I give consent for my physician to view/request my prescription history _____
Initials

Family History: Specify the family member with any of the following applicable medical histories

Has any relative ever had:	Specify Family Member	Specify Maternal or Paternal and Living or deceased
Arthritis at an Early Age		
Bleeding Problems		
Cancer (Type: _____)		
Congestive Heart Failure		
Diabetes		
Gout		
Hypertension/High BP		
Scoliosis		
Stroke		
Tuberculosis		
Other: _____		

Past Medical History:

Social History:

Do you smoke tobacco? Never smoked Former smoker Current some day smoker Current every day smoker

How often do you consume alcoholic beverages? Never Rarely Moderately Daily

What is your Occupation? _____ Are you in School? Yes No

If in school, what is the school's name? _____ What year of school are you in? _____

How many hours per week do you exercise? _____ Sports played during the year _____

If under 18, with whom do you live? _____

Gynecological (If Applicable):

Age first period started? _____ How long do periods usually last? _____ Frequency of periods? _____

Date of your last period? _____

Surgical History: List any past Surgeries

Patient Name: _____ Patient Date of Birth: _____ Today's Date _____



Office Policies/ Procedures

Please read the following office policies/procedures and sign your name below

I understand that as the patient, I am required to pay for services rendered at the time of visit. I understand that I am responsible for all the charges regardless of my insurance carrier's involvement; I authorize Primary Care Sports Medicine to charge the credit card on file for medical services rendered and associated charges for any *past due* balances owing towards my account including co-pays and deductibles that are **more than 60 days past due**.

Please note: You will receive a courtesy call from our collections department prior to charging your card to discuss payment options. Three attempts will be made to reach you. If we are unable to reach you after 2 weeks, your card will be charged. Initial here: _____

I understand that it is my responsibility to be fully informed as to what is excluded or payable from the insurance carrier, as well as the limitations, co-payments and deductibles. Due to the fact that there are many types of insurance plans, it is the responsibility of the patient to be fully informed as to what the requirements, benefits, or limitations are regarding coverage, please refer to your personal department or insurance representative. I authorize payment of any expenses incurred for the services rendered by Primary Care Sports Medicine. **Initial here: _____**

As a condition of servicing the health care needs listed above I hereby attest that I am an "eligible" member of the Health Plan, indicated. I further hereby attest and agree that should I later be deemed "*ineligible*" for the services rendered by this provider, I am responsible for payment in full for the services rendered at Primary Care Sports Medicine at the Self pay rate. **Initial here: _____**

Return Check Policy: There will be a charge of **\$45** for any check that is returned. **If your check is returned to us, all fees, co-pays and balances must be paid with Cash or Credit Card from that point on.**

Additional Forms and Medical Records: There will be a **\$25** charge for each form that needs to be filled out by our office and medical record request that are above and beyond those that are given to you at the time of your visit. **Examples: Accident Claim Forms, disability forms or forms requiring a 'Physician Statement'.**

X-Rays: You can purchase a copy of your digital X-Rays in a CD for **\$5**. Please contact our office at least 1 day in advance for instructions on how to order these.

"I have read and understood the above policies and procedures".

Signature of Patient/ Legal Guardian

Print Name

Date



Notice of Privacy Practices Acknowledgement Form

THE NOTICE OF PRIVACY PRACTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AS IT EXPLAINS:

- **How this office will use and disclose your protected health information.**
- **Your privacy rights with regard to your protected health information.**
- **This office's obligations concerning the use and disclosure of your protected health information.**

I acknowledge that I have received a copy of the office Notice of Privacy Practices. I further acknowledge that the office Notice of Privacy Practices is available at the front desk upon request.

Patient or Patient Representative Signature

Date

Patient or Patient Representative Printed Name