ADULT Patient Questionnaire

18-25

PRIMARY CARE PCSM SPORTS MEDICINE

18411 Clark St, Ste 302
Tarzana, CA 91356

Patient Information		
FIRST AND LAST NAME		DATE OF BIRTH
HOME ADDRESS	CITY	STATE AND ZIP
HOME PHONE		CELL PHONE
EMAIL ADDRESS		
PRIMARY PHYSICIAN	CITY	PHONE
PREFERRED PHARMACY	CITY	PHONE

PERSON WHO IS FINANCIALLY RESPONSIBLE FOR THE PATIENT:

FIRST AND LAST NAME	DATE OF BIRTH	HOME PHONE #	CELL PHONE #
BILLING ADDRESS		EMAIL ADDRESS:	

EMERGENCY CONTACT:

NAME	PHONE NUMBER	RELATION

HOW DID YOU HEAR ABOUT US?

[ ] yelp [ ] Online *Source: _____ [ ] Physician :_____ [ ] Friend: _____
[ ] Family Member: _____ [ ] Other: _____

INSURANCE CARRIER:	BILLING ADDRESS IF DIFFERENT FROM ABOVE
SUBSCRIBERS NAME AND DOB	

Patient Acknowledgement of PCSM Education Site

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.

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.

PLEASE READ CAREFULLY AND CHOOSE ONE OPTION ONLY

While providing this service is important to us, your comfort is more important. Please indicate below your preference.

___ **I AM** comfortable with having students/residents ***Observe, ask questions about my injury/nature my visit, take my vitals and perform a brief physical exam (only by a resident physician)*** during my visit to further their learning.

___ **I AM NOT** comfortable with having students/residents present during my visit.

___ **I AM** comfortable having students/residents **OBSERVE ONLY.**

Signature :_____ Date :

PRIMARY CARE
PCSM
SPORTS MEDICINE

Please complete the following Medical Questionnaire

Review of Systems: (Please check those that apply)

Constitutional:		
☐Chills	☐Decline in Health	☐Fatigue
☐Fever	☐Weakness	☐Weight Gain
☐Weight Loss		
Head:		
☐ Dizziness	☐Fainting	☐Head Injury
☐Headaches	☐ Pain	☐Sweats
Eyes:		
☐ Blurry Vision	☐Discharge	☐ Double Vision
☐Eye Pain	☐Eyeglass Use	☐Pain with Light
☐Recent Injury	☐ Unusual Sensations	☐ Vision Loss
ENT:		
☐ Discharge (nose)	☐Hay Fever	☐Infections
☐Nasal Obstruction	☐Nosebleeds	☐Sinus Infection
☐Discharge (ears)	☐ Hearing Aid	☐ Hearing Impairment
☐ Pain (ears)	☐Ringing in Ears	
Respiratory:		
☐Asthma	☐Cough	☐Wheezing
☐Bronchitis	☐Coughing Blood	☐Pain
☐Pleurisy	☐ Positive TB Test	☐Recent Chest X-Ray
☐Short of Breath	☐Sputum	☐Tuberculosis
Cardiovascular:		
☐Chest Pain	☐Palpitations	☐Extremity(s) Cool
☐Heart Murmur	☐High Blood Pressure	☐History of Heart Attack
☐Short of Breath-Exertion	☐Short of Breath-Lying Flat	☐Thrombophlebitis
Gastrointestinal:		
☐Abdominal Pain	☐Constipation	☐Diarrhea
☐Heartburn	☐Excessive Hunger	☐Excessive Thirst
☐Hepatitis	☐Nausea	☐Vomiting
Musculoskeletal:		
☐Arthritis	☐Joint Pain	☐Gout
☐Back Problems	☐Deformities	☐Joint Stiffness
☐Muscle Cramps	☐Muscle Stiffness	☐Paralysis
☐Restricted Motion	☐Weakness	
Skin:		
☐Eczema	☐Itching	☐Easy Bruisability
☐Hives	☐Lumps	☐Skin Color Change
Neurological:		
☐Loss of Consciousness	☐Blackouts	☐Burning
☐Dizziness	☐Fainting	☐Head Injury
☐Headaches	☐Numbness	☐Paralysis
☐Strokes	☐Tingling	☐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

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