New Patient History & Intake Form

Patient Information

Patient Name: ______________________________ Date of Birth: ____________________________

Date of Visit (Today's Date): ____________________ Date of Injury (if applicable): ________________

Reason For Visit: ____

Primary Care Provider: _________________________ Referring Provider: _________________________

Height_______________Weight________________ Right or Left Handed:_______________________

Preferred Language: _______________ Race: _______________ Ethnicity: _______________________

Pharmacy Name:_______________________ Pharmacy Number: ______________________________

Past Medical History (please check all that apply):

- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Irregular Heartbeat
- ☐ Bipolar Disorder
- ☐ Breast Cancer
- ☐ Hyperlipidemia
- ☐ Ischemic Heart Disease
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non Insulin
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity, Morbid
- ☐ Obesity
- ☐ PBPH
- ☐ Prostate Cancer
- ☐ Pulmonary Embolism
- ☐ Radiation Therapy
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke
- ☐ **None**
- ☐ Other__________________

Past Surgical History (please check all that apply):

- ☐ Appendix (Appendectomy)
- ☐ Breast: Mastectomy
  ○Right ○Left ○Both
- ☐ Breast: Lumpectomy
  ○Right ○Left ○Both
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Gallbladder Removal
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Removed: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Hysterectomy
- ☐ Hysterectomy: Caesarean
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ **None**
- ☐ Other__________________

Past Orthopedic History (please check all that apply):

- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Bursitis
- ☐ DISH
- ☐ Epidural Injections, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ **None**
- ☐ Other_______________

Past Orthopedic Surgery (please check all that apply):

- ☐ Achilles Tendon Repair
  ○Right ○Left ○Both
- ☐ ACL Reconstruction
  ○Right ○Left ○Both
- ☐ Ankle Fracture ORIF
  ○Right ○Left ○Both
- ☐ Bunion Correction
  ○Right ○Left ○Both
- ☐ Carpal Tunnel Decompression
  ○Right ○Left ○Both
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ Distal Radius ORIF
  ○Right ○Left ○Both
- ☐ Ganglion Cyst Excision
- ☐ Intermedullary Nailing Femur
  ○Right ○Left ○Both
- ☐ Intermedullary Nailing Tibia
  ○Right ○Left ○Both
- ☐ Joint Replacement: Hip
  ○Right ○Left ○Both
- ☐ Joint Replacement: Knee
  ○Right ○Left ○Both
- ☐ Joint Replacement: Shoulder
  ○Right ○Left ○Both
- ☐ Knee Arthroscopy
  ○Right ○Left ○Both
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Lumbar Fusion
- ☐ Lumbar Laminectomy
- ☐ Lumbar Spine Surgery: Decompression
- ☐ Lumbar Spine Surgery: Decompression & Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement
- ☐ Meniscus Repair
  ○Right ○Left ○Both
- ☐ Reverse Total Shoulder Replacement
  ○Right ○Left ○Both
- ☐ Revision of Total Knee Arthroplasty
  ○Right ○Left ○Both
- ☐ Revision of Total Shoulder Arthroplasty
- ☐ ○Right ○Left ○Both
- ☐ Rotator Cuff Repair
  ○Right ○Left ○Both
- ☐ Shoulder Arthroscopy
- ☐ ○Right ○Left ○Both
- ☐ Trigger Finger Release
  Location: _______________
- ☐ Other_______________

Medications (please list all current medications or check option which applies):

- ☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)
- ☐ Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

Allergies (please list all known allergies or check option which applies):

- ☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)
- ☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

Family History (please inform us of your family members' medical history by marking the appropriate box):

	Mother	Father	Sister	Brother	Daughter	Son	Other:
Hypertension							
Osteoarthritis							
Osteoporosis							
Scoliosis							
Diabetes, Type 2							
*Other*__________________							

☐ **No Family History** (checking this box indicates no past family medical history)

Social History (please check all that apply):

Cigarette Smoking
- ☐ Never Smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily
  - # packs per day____

Alcohol Use
- ☐ Do not drink alcohol
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Exercise Frequency
- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never
- ☐ Other____________

VACCINATION STATUS

For patients 65 and older: Have you received a pneumonia vaccination?

A) Yes
B) No

ADVANCE CARE

Do you have a health care proxy in the event you are unable to make your own medical decisions?

A) Yes
B) No

Do you have a living will?

A) Yes
B) No

Which statement best reflects your wishes on advanced care recommendation?

A) Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
B) Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.
C) Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

CHECK IF YOU HAVE THESE SYMPTOMS

SYMPTOM	YES
Joint pains	
Joint swelling	
Joint stiffness	
Unsteady gait	
Numbness	
Tingling	
Dizziness	
Headaches	
Tremors	
Fatigue	
Unexpected weight loss	
Fever	
Chills	
Weight gain	
Poor healing wounds	
Scarring/Keloids	
Easy bleeding	
Easy bruising	
Allergic reaction to food/environment	
Chest pain	
Palpitations	
Heart murmur	
Excessive thirst or urination	
Heat/cold intolerance	
Nose bleeds	
Ringing in ears	
Hoarseness	
Corrective lenses	
Blurred Vision	
Heartburn	
Nausea/Vomiting	

Constipation	
Diarrhea	
Bloody/tarry stools	
Frequent urination	
Difficult/painful urination	
Incontinence	
Blood in urine	
Shortness of breath	
Wheezing	
Cough	
Anxiety/depression	
Hallucinations	
ALERT	YES
Pacemaker	
Blood thinners	
Defibrillator	
Pregnant or planning a pregnancy	
RSD	
Allergy to shellfish/iodine	
Allergy to latex	
Allergy to adhesive	
Under pain management	
HIV Positive	
Hepatitis position (A,B or C)	
I agree that Sparks Orthopedics and Sports Medicine may request	
my prescription history from my pharmacy and use it for	
treatment purposes.	
Signature____	
Date__/__/__	

Sparks Orthopedics And Sports Medicine
Dan Sparks, M.D. Daniel Sparks, M.D.
Dierick Sparks, M.D.
3102 Rainbow Drive Rainbow City , AL 35906

Date______________________ Home Phone________________________________
Patient (last,first,middle initial)______________________________________
Responsible Party (if minor)____
Street Address ____
City____________ State____________________ Zip Code__________________
Sex M F Age______________ Birthdate ____________ Marital Status M S D W
Social Security # _________________ Spouse Social Security # ______________
Patient Employer____
Business Address____
Occupation________________________________ Business Phone____________
Spouse Name_______________________________ Birthdate________________
Business Name & Address____
Occupation______________________________ Business Phone______________
In Case of Emergency, who should be notified?_________________Phone__________
How did you learn of our practice? ______________________________________
Primary Care Physcian:__________________ Referring Physician:_________________
Email____________________

INSURANCE

Who is Responsible for Account?________________ Relationship to Patient__________
Do you have Medical Insurance? **YES NO** Insurance ____________________________
Name of Primary Insurer _______________Date of Birth__________ Relationship______
Social Security Number____________ Contract #_____________ Group # ____________
Name of Secondary Insurer ______________ Contract #______________ Group # _____

ASSIGNMENT and RELEASE

I, the undersigned, have insurance coverage with_________________ and assign directly to Dr Dan Sparks/Dr Daniel Sparks/Dr Dierick Sparks all my medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

______________________________ ______________________________
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Dan Sparks/Dr Daniel Sparks/Dr Dierick Sparks for any services furnished me by that physician. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________________ ______________________________
Beneficiary Signature Date

SPARKS ORTHOPEDICS AND SPORTS MEDICINE

PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Patient Name: ____

Date of Birth: ____________ Social Security Number: ______________________

Acknowledgement of receipt of Privacy Practices Notice:

I,______________________________, acknowledgement that I have received a Privacy Practices Notice from: Sparks Orthopedics and Sports Medicine. Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices.

Patient Signature: ___________________________ Date: ________________________

If a personal representative on behalf of the individual signs the authorization, complete the following:

Personal Representative's Name: ______________________________________

Relationship to Individual:____

IF NOT SIGNED: (Good faith effort to obtain acknowledgement of receipt)

Describe your good faith effort to obtain the individual's signature on this form: ______________

____

SIGNATURE:_________________________ DATE:______________________________

PRINT NAME:________________________ TITLE:______________________________

SPARKS ORTHOPEDICS AND SPORTS MEDICINE

3102 Rainbow Drive
Rainbow City, AL 35906

EMAIL AUTHORIZATION AGREEMENT

Privacy and security or E-mail:

Do not use E-mail to send or request sensitive information. This includes personal information you do not want other people to know about. Additionally, you should be aware of and understand that if you use E-mail provided by your employer, any E-mail sent on your employer's system may be viewed by your employer.
SPARKS ORTHOPEDICS cannot and does not guarantee the privacy or security of any messages being sent over the Internet. There is the potential that E-mail sent over the Internet can be intercepted and read by others. If this is of concern to you, you should not communicate with your healthcare provider through E-mail.
This document along with Sparks Orthopedics "Notice of Privacy Practices" constitutes a notice of privacy practices for E-mail use.

Authorization to use E-mail:

I have been informed of and understand the risks and procedures involved with using E-mail. I agree to the terms listed on this forma and hereby voluntarily request, consent to and authorize the use of E-mail as one form of communication with my physician, his/her associates, technicians and other healthcare providers. (You will be given a copy of this signed form to keep for your records.)

Patient Signature: ______________________________ Date: ______________

Patient Representative: __________________________ Relationship: __________

Patient E-mail address: ____

Physician Signature: ____________________________ Date: ______________

Physican E-mail address: _________________________ Phone: _____________

PRESCRIPTION HISTORY CONSENT:

I give my consent to have **Sparks Orthopedics** to obtain my prescription history from external sources.

Patient or Authorized Person's Signature: ________________________________

Date: ____________________

SPARKS ORTHOPEDICS AND SPORTS MEDICINE

3102 Rainbow Drive
Rainbow City, AL 35906

Name of local friend or relative (not living at same address):	Relation to Patient:	Home Phone #:	Work Phone #:
______________________	____________	__________	__________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sparks Orthopedics or insurance company to release any information required to process my claims.

Patient/Guardian Signature: ______________________________ *Date* ______________________

AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION:
All PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT, NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS, THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR THE SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. ALL COPAYS ARE PAYABLE AT THE TIME OF SERVICE.
THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE **SPARKS ORTHOPEDICS** TO FURNISH THE INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENTS) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO **SPARKS ORTHOPEDICS** ALL PAYMENTS FOR MEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.
I HEREBY AUTHORIZE AND RELEASE THE DOCTOR AND WHOMEVER HE/SHE MAY DESIGNATE AS HER /HIS ASSISTANT TO ADMINISTER TREATMENT, PHYSICAL EXAM, X-RAY, MEDICAL CARE OR ANY CLINICAL SERVICE THAT HE/SHE DEEMS NECESSARY IN MY CASE. I FURTHER AUTHORIZE HIM/HER TO DISCLOSE ALL OR PART OF MY RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE UNDER CONTRACT TO THE CLINIC OR THE PATIENT OR TO A FAMILY MEMBER OR EMPLOYER OF THE PATIENT FOR ALL OR PART OF THE CLINIC CHARGE, INCLUDING BUT NOT LIMITED TO HOSPITAL OR MEDICAL SERVICES COMPANY, WORKERS COMPENSATION CARRIERS, WELFARE FUNDS, OR THE PATIENTS EMPLOYER.

PATIENT INFORMATION CONSENT:
I UNDERSTAND THAT **SPARKS ORTHOPEDICS** MAY NEED TO USE AND DISCLOSE INFORMATION ABOUT MY HEALTH OR MEDICAL PROBLEMS FOR THE PURPOSE OF ARRANGING, CONDUCTING, OR REFERRING MY TREATMENT, FOR OBTAINING PAYMENT FOR SERVICES, AND FOR THE PURPOSE OF OPERATING THE PRACTICE. I CONSENT TO THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONG.

I UNDERSTAND THAT MY CONSENT IS NOT NEEDED IF THE LAWE REQUIRES **SPARKS ORTHOPEDICS** TO REPORT SOME ASPECT OF MY PROTECTED HEALTH INFORMATION TO A GOVERNMENT AGENCY (FOR EXAMPLE, SUSPECTED ABUSE, COMMUNICABLE DISEASE AND POTENTIAL BODILY HARM TO MYSELF OR OTHERS).

I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW **SPARKS ORTHOPEDICS** PRIVACY NOTICE TO REQUEST RESTRICTIONS BE PUT ON THE USE OF MY INFORMATION, AND REVOKE MY CONSENT AT A LATER DATE.

I UNDERSTAND THAT IF I WITHHOLD CONSENT FOR THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT OR OPERATION, **SPARKS ORTHOPEDICS** MY REFUSE TO UNDERTAKE MY CARE.

I, THE UNDERSIGNED, HEREBY CONSENT TO THE FOLLOWING TREATMENT: ADMINISTRATION AND PERFORMANCE OF ALL TREATMENTS, ADMINISTRATION OF ANY NEEDED ANESTHETIC, PERFORMANCE OF SUCH PROCEDURES AS MY BE DEEMED NECESSARY OR ADVISABLE IN THE TREATMENT OF THIS PATIENT, USE OF PRESCRIBED MEDICATION, PERFORMANCE OF DIAGNOSTIC PROCEDURES/TESTS, CULTURES, BIOPSIES AND SURGERY, PERFORMANCE OF OTHER MEDICALLY ACCEPTED LAB TESTS THAT MAY BE CONSIDERED MEDICALLY NECESSARY OR ADVISABLE BASED ON THE JUDGEMENT OF THE ATTENDING PHYSICIAN OR THEIR ASSIGNED DESIGNESS. I FULLY UNDERSTAND THAT THIS IS GIVEN IN ADVANCE OF ANY DIAGNOSIS OR TREATMENT. I UNDERSTAND THIS CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING, I UNDERSTAND THAT **SPARKS ORTHOPEDICS** MAY INCLUDE CONSENT AT SATELLITE OFFICES UNDER COMMON OWNERSHIP.

MEDICARE PATIENT: I AUTHORIZE TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES FOR MY MEDICARE CLAIMS. I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TO **SPARKS ORTHOPEDICS.**

HIPPA ACKNOWLEDGMENT: I HAVE RECEIVED AND READ **SPARKS ORTHOPEDICS** NOTICE OF PRIVACY PRACTICES. IN MY ABSENCE OR FOR THE BENEFIT OF GAINING MEDICAL ADVICE ON MY BEHALF, I AUTHORIZE THE FOLLOWING PERSON TO GAIN PATIENT HEALTH INFORMATION FOR OR WITH ME:
(NAME) ____

I CERTIFY THAT I HAVE READ AND FULLY UNDERAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENT, AND ALSO THAT ALL INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO MY KNOWLEDGE.

____ ______________________

Patient/Guardian Signature Date

SPARKS ORTHOPEDICS & SPORTS MEDICINE

Danny R. Sparks, M.D. • Dierick R. Sparks, M.D. • Daniel R. Sparks, M.D.

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to Sparks Orthopedics and Sports Medicine. I am financially responsible for ALL NON-COVERED services. I also authorize the physician to release any information required to process my claim to my employer or insurance company.

(Signature of patient or parent if minor)__________________________Date:__________________

I give permission for my medical information or test results to be released to the following people:

1.___________________________________Relationship___________________________________

2.___________________________________Relationship___________________________________

3.___________________________________Relationship___________________________________