PATIENT HISTORY
BEACON ORTHOPAEDICS & SPORTS MEDICINE

Name:_____ Age: _____ D.O.B._____ Date: _____
Chief Complaint: _____
Was this due to an injury? Yes____ No____ Date of Injury _____ Did this occur at work? Yes _____ No _____
Has the injury been treated? Yes____ No ____ If yes, how has this been treated and by whom?_____
_____
Have you had a previous similar injury? Yes ____ No____ Please explain:_____
Current Weight: _____ 1 year ago _____Height _____ ~~Blood Pressure~~_____ Occupation:_____
Gender: Male: _____ Female_____ Race: _____ Ethnicity:_____ Preferred Language: _____
Marital Status: S___ M ___ W___ D____ Do you live alone? Yes ___ No ___ Hobbies/Sports: _____
Do you Smoke? Quit___Yes ____ No____ If yes how many per day? _____ Total years you have smoked?____ Have you ever tried to quit? Y____ N____
Do you consume alcohol? Yes ____ No ____ If yes how much per week?_____ _____
Name of Primary Care Physician: _____
~~Drug Allergies~~ _____
Latex Allergy? _____ Yes _____ No
~~Current Medications~~: _____
_____
Hospitalizations or Previous Surgeries: _____
Past Medical Problems: _____
Have you ever had a blood transfusion? _____ yes _____ no If yes give date: _____

PLEASE USE BACK OF FORM TO ADD ANY OTHER PERTINENT INFORMATION

Have you or your family members had any of the following conditions? (Please check all that apply):

	Self Yes no	Mother Yes no	Father Yes no	Children/Other Relatives Yes no
Heart Disease	___ ___	___ ___	___ ___	___ ___
High Blood Pressure	___ ___	___ ___	___ ___	___ ___
Stroke	___ ___	___ ___	___ ___	___ ___
Cancer	___ ___	___ ___	___ ___	___ ___
Glaucoma	___ ___	___ ___	___ ___	___ ___
Diabetes	___ ___	___ ___	___ ___	___ ___
Epilepsy/Convulsions	___ ___	___ ___	___ ___	___ ___
Bleeding Disorder	___ ___	___ ___	___ ___	___ ___
Thyroid Disease	___ ___	___ ___	___ ___	___ ___
Mental Illness	___ ___	___ ___	___ ___	___ ___
Osteoporosis	___ ___	___ ___	___ ___	___ ___
Tuberculosis	___ ___	___ ___	___ ___	___ ___
Kidney Disease	___ ___	___ ___	___ ___	___ ___

For Women Only:
Pregnant: Yes ___ No ___

Last Menstrual Period: _____

Are there any other serious illnesses /health conditions affecting you or your family of which we should be aware?
Yes ___ No _____
_____
_____

Please check if you have ever had the symptom listed – Check all that apply

Constitutional	Eyes	ENT/Mouth	Cardiovascular	Respiratory
___Fever	___Double Vision	___Deafness	___Chest Pain	___Shortness of Breath
___Weight Loss	___Blurring	___Sinusitis	___Heart Murmur	___Asthma
___Fatigue	___Trauma	___Ringing in Ears	___High Blood Pressure	___Lung Disease
		___Dizziness	___Heart Attack	___Bronchitis
		___Balance Problems	___Irregular Rhythm	___Pneumonia
GI	**GU**	**Musculoskeletal**	**Neurological**	**Psych**
___Weight Change	___Leaking Urine	___Fracture	___Seizures/Epilepsy	___Depression
___Diarrhea	___Prostate Disease	___Pain	___Weakness	___Sleep Disorder
___Constipation	___Pain with Urination	___Swelling	___Stroke	___Memory Problems
___Ulcer	___Frequent Urination	___Arthritis	___Headaches	
___Gallbladder Disease	___Kidney Stones	___Spasm/Muscle	___Blackouts/Fainting	
___Change In Bowel Habits		___Gout	___Tremble	
		___Rheumatoid Arthritis	___Head Injuries	
Vascular	**Hematologic**	**Allergy/Immunology**	**Skin/Breast**	
___Blood Clots	___Hepatitis	___Hay Fever	___Breast Abnormality	
___Poor Circulation	___Anemia	___Dermatitis	___Change in Skin/Hair	
	___Lymph Node			
	___AIDS			

Patient Signature _____ Date _____
Reviewed By _____ MD Date _____

Note: This is a confidential Record of your medical history and will be maintained in this office. The information contained here will not be released to any person except who you have authorized to do so.

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Patient Name: _____ DOB: _____

Medications List

Allergies

_____ _____

_____ _____

Please list any medications you are currently taking

Drug Name	Dosage	Directions	Reason Taking

Preferred Pharmacy: _____ Date: _____

Location/Number: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided with and understand this facility's Notice of Privacy Practices (HIPAA information). This notice provides a complete description of the uses and disclosures of my health information.

Patient Name: _____ Date of birth: _____

_____ _____
*Patient or Representative Signature Date

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient
(ex: parent, power of attorney)

**If the patient is a minor child or otherwise unable to sign this authorization, then obtain the signature of the authorized individual. If person is POA, we must have a copy of the Power of Attorney paperwork.*

Consent to Be Contacted

Beacon Orthopaedics & Sports Medicine, or third parties on our behalf, may need to contact you regarding your healthcare or your account with us. Those communications may include appointment and exam confirmation and reminders, wellness checkups, pre-registration instructions, pre-operative instructions, post-discharge instructions, post-appointment follow-up, prescription notifications, and other messages relating to your care, scheduling, benefits, billing, payment, or other financial responsibilities. By providing your phone number, you agree to receive calls or text messages from Beacon Orthopaedics & Sports Medicine, or a third party on its behalf, at the number you have provided. Such calls may be placed using an automatic telephone dialing system.

Please provide your preferred contact information below.

Name: _____

Cell Phone Number: _____ Home Phone Number: _____

☐ I would like to receive emails from Beacon Orthopaedics & Sports Medicine regarding new services, educational content, events, and other content related to orthopaedic conditions/treatment options.

Email Address: _____

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Designation of a Personal Representative Form

Patient Name: _____ **Date of Birth:** _____

A patient may designate a personal representative in writing. This person may be a spouse, adult child, members of the patient's family, or close friend. They may also be any individual with power of attorney or other legally recognized authority to make medical decisions on behalf of the patient if he or she is incapacitated or otherwise unable to make decisions. As a general rule, a parent or legal guardian of a minor child will be recognized as their personal representative.

A personal representative may act on behalf of the patient for the purpose of receiving information that otherwise would be given to the patient. Such information could include appointment changes, messages regarding surgery and/or testing, physician's responses to phone messages and medication requests. An answering machine cannot be used as an acceptable way of leaving information. A staff member may refuse to disclose information to a person identified as a patient's personal representative if he/she believes such information should be given directly to the patient.

Please note: **This form does not grant permission to release medical records to these designated representatives.**

Person(s) to whom my information may be disclosed:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Patient/Representative Signature: _____ Date: _____

If patient is a minor, please provide the following information:

Mother's Name: _____
AND
Father's Name: _____

OR Legal Guardian(s): _____

You may revoke or terminate this authorization at any time by submitting a written revocation to Beacon Orthopaedics & Sports Medicine, Ltd./Beacon Orthopaedics Surgery Center, LLC. Revised March 2019.

Beacon Orthopaedics and Sports Medicine, LLC Financial/Credit Policy

Effective April 2009

Patient Name: _____ **Patient Date of Birth:** _____

Please Print

Beacon Orthopaedics and Sports Medicine, LLC (BOSM) believes that in the interest of good health care practices, it is best to establish a patient financial/credit policy between our patients and ourselves in order to avoid any misunderstandings. Our Account Representatives will be glad to discuss your account with you at any time and set up payment plans. Our primary responsibility is to deliver quality health care services. We wish to spend our time and energy toward that responsibility. We expect you to show us the same consideration as you do your other creditors, and to be honest and forthright regarding your financial responsibility.

(PLEASE INITIAL THE FOLLOWING)

_____1.) **We expect that all co-pays, co-insurance and deductible be paid in full at each visit and prior to surgery, diagnostic testing and physical therapy.** We accept cash, check, Debit Card, MasterCard, VISA, American Express, Discover and Care Credit.

_____2.) **We file claims to your insurance company for your primary and secondary policies.** You must bring your insurance card with you to every visit and make us aware of any change in coverage. We also require a copy of your driver's license to confirm identity. Please remember insurance coverage is a contract between the patient and the insurance company. When BOSM files for benefit for services performed, benefits are assigned to BOSM. BOSM will look to the patient for payment in full if insurance does not cover the services provided. If we do not participate with your insurance, you will likely have a higher out-of-pocket expense, so please be prepared to pay this amount.

_____3.) ***We do not file any insurance with your Automobile Insurance Company, or any other third party (business insurance company, employer, attorney, separated spouses, etc.) for the purpose of obtaining payment.*** We will make every effort to provide you with proper documentation for you to receive reimbursement from those parties (i.e., claim form, statement or report). Please speak with our billing representative. We do not accept Letters of Guarantee or other promises to pay when cases settle. You will be extended credit only if arrangements are made in advance and only within our standard guidelines for credit.

_____4.) **If the patient is under age 18, a parent or guardian must sign below.** If the minor does not reside with both parents, and there is a dispute over which parent is responsible for any remaining balances, we will ultimately rely upon the parent/guardian who brought the child to the office for financial responsibility. All minors will not be seen unless accompanied by a guardian or a signed authorization from that guardian allowing our physicians to provide medical treatment.

_____5.) **A service charge of $20.00 will be applied to returned checks.** You will be asked to bring cash, money order or cashiers check to our office to cover the amount of the check plus the service charge. If you present two (2) checks that are returned to us, we will require cash for future services.

_____6.) **If your balance is not paid in a timely manner, we reserve the right to forward your account to an outside collection agency or attorney.** All fees assessed by the agency or attorney will be charged to you and become a part of your outstanding balance.

By signing this agreement, you are acknowledging that you understand our financial/credit policy, and agree to pay for all services that are received.

Name - Person Completing Form (Print): _____ Birthdate of Person: _____

Signature - Person Completing Form: _____ Date: _____