

Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Chart: \_\_\_\_\_  
 Age: \_\_\_\_\_  
 Date: \_\_\_\_\_



**PATIENT HISTORY FORM**

Nickname: \_\_\_\_\_

Are you:  Right handed  Left handed  Ambidextrous  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Medical History:** Do you currently or have had any of the following?  NONE

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> seizures                 | <input type="checkbox"/> stroke                  | <input type="checkbox"/> diabetes              | <input type="checkbox"/> hypothyroidism            |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> coronary artery disease | <input type="checkbox"/> heart attack          | <input type="checkbox"/> heart murmur              |
| <input type="checkbox"/> high blood pressure      | <input type="checkbox"/> high cholesterol        | <input type="checkbox"/> irregular heart beat  | <input type="checkbox"/> pacemaker                 |
| <input type="checkbox"/> asthma                   | <input type="checkbox"/> COPD                    | <input type="checkbox"/> sleep apnea / CPAP    | <input type="checkbox"/> reflux / heartburn        |
| <input type="checkbox"/> stomach ulcers           | <input type="checkbox"/> colitis                 | <input type="checkbox"/> Crohn's disease       | <input type="checkbox"/> hepatitis / liver disease |
| <input type="checkbox"/> kidney disease           | <input type="checkbox"/> arthritis               | <input type="checkbox"/> chronic pain          | <input type="checkbox"/> gout                      |
| <input type="checkbox"/> fibromyalgia             | <input type="checkbox"/> osteomyelitis           | <input type="checkbox"/> osteoporosis          | <input type="checkbox"/> anemia                    |
| <input type="checkbox"/> bleeding disorder        | <input type="checkbox"/> blood clots             | <input type="checkbox"/> HIV / AIDS            | <input type="checkbox"/> MRSA / VRE                |
| <input type="checkbox"/> poor circulation         | <input type="checkbox"/> cancer _____            | <input type="checkbox"/> depression            | <input type="checkbox"/> drug / alcohol problem    |
| <input type="checkbox"/> psychiatric illness      | <input type="checkbox"/> pregnancy (current)     | <input type="checkbox"/> other / details _____ |  |

**Surgical History:**  NONE. Circle all that apply:

- Eyes / ENT: cataracts, vision correction, sleep apnea, tonsils, sinus surgery, thyroid, other \_\_\_\_\_
- Heart: bypass, valve replacement, stent, other \_\_\_\_\_
- Lung: resection, other \_\_\_\_\_
- Gastrointestinal: appendix, gall bladder, hernia, other \_\_\_\_\_
- Gynecologic: C-section, hysterectomy, tubal ligation, other \_\_\_\_\_
- Urologic: prostate, bladder, vasectomy, other \_\_\_\_\_
- Orthopaedic: joint replacement, arthroscopy, fracture surgery, spine, other \_\_\_\_\_
- Vascular: carotid, aneurysm, bypass, other \_\_\_\_\_
- Neurosurgical: aneurysm, tumor, craniotomy, other \_\_\_\_\_
- Cancer: skin, breast, thyroid, other \_\_\_\_\_
- Other: \_\_\_\_\_

**Anesthesia Complications:**  NONE. If yes, explain: \_\_\_\_\_

Would you accept blood products or blood transfusions as needed at the discretion of your provider?  yes  no

**Medications:**  NONE  additional sheet attached  Are you taking any blood thinners?  Have you taken chronic steroids?

Medication (include over the counter medicines and nutritional supplements)	Dose and Frequency
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

**Medical Allergies:**  NONE  penicillin  sulfa  latex  metals  tape  iodine (IV contrast)  shellfish  
 poultry products  anti-inflammatories  other \_\_\_\_\_

Name:  
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**Social History:**

Alcohol Use:  none  occasional  weekly  daily  
Tobacco Use:  none  previous When did you quit? \_\_\_\_\_  current packs / day: \_\_\_\_\_  
When did you start? \_\_\_\_\_  
Recreational Drug Use:  none  previous  current drug \_\_\_\_\_ Last used? \_\_\_\_\_

**Fall Assessment:**

Have you fallen 2 or more times in the past year?  yes  no Have you seen anyone regarding your fall?  yes  no  
Have you had any falls with injury in the past year?  yes  no

**Other Current Symptoms:** (within the last 4 weeks)  NONE. Circle all that apply:

- yes  no Constitutional: unexpected weight loss, weight gain, fever, chills, night sweats, fatigue \_\_\_\_\_
- yes  no Eyes: blurred /double vision, eye pain, redness, watering \_\_\_\_\_
- yes  no ENT: headache, difficulty swallowing, nose bleeds, ringing in ears, earaches \_\_\_\_\_
- yes  no Cardiovascular: chest pain, palpitations, fainting, murmurs \_\_\_\_\_
- yes  no Respiratory: shortness of breath, wheezing, coughing, painful breathing, snoring \_\_\_\_\_
- yes  no Gastrointestinal: heartburn, nausea, constipation, incontinence, diarrhea, bloody/black stools \_\_\_\_\_
- yes  no Genitourinary: urinary frequency, urgency, difficulty, pain, bleeding, incontinence \_\_\_\_\_
- yes  no Musculoskeletal: other joint pains, swelling, instability, stiffness, redness, heat, muscle pain \_\_\_\_\_
- yes  no Skin: skin changes, poor healing, rash, itching, redness, foot ulcers \_\_\_\_\_
- yes  no Neurological: numbness /tingling, unsteady gait, dizziness, tremors, seizures \_\_\_\_\_
- yes  no Psychological: nervousness, anxiety, depression, hallucinations, confusion \_\_\_\_\_
- yes  no Hematologic: easy bleeding, bruising \_\_\_\_\_
- yes  no Endocrine: excessive thirst or urination, heat / cold intolerance \_\_\_\_\_
- yes  no Other: \_\_\_\_\_

**Family History** (mother / father / siblings):  NONE OF THE BELOW

- anesthesia complications \_\_\_\_\_
- arthritis \_\_\_\_\_
- bleeding disorder/blood clots \_\_\_\_\_
- cancer \_\_\_\_\_
- diabetes \_\_\_\_\_
- heart disease \_\_\_\_\_
- high blood pressure \_\_\_\_\_
- kidney disease \_\_\_\_\_
- thyroid disease \_\_\_\_\_
- other \_\_\_\_\_

**Occupation:** \_\_\_\_\_

My duties consist of:  
Sitting: \_\_\_\_\_ hours Standing: \_\_\_\_\_ hours Lifting: \_\_\_\_\_ pounds Repetitive Motion:  yes  no  
Are you presently working?  yes  no If no, when was your last date worked? \_\_\_\_\_  
Will your employer allow you to return to work with restrictions?  yes  no  
if unemployed explain why: \_\_\_\_\_

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Updated Signatures (if hx changed)**

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

**PAIN MEDICATION POLICY  
BEACON ORTHOPAEDICS AND SPORTS MEDICINE**

The purpose of this agreement is to prevent any misunderstanding about the distribution of medications from the Beacon Orthopaedics and Sports Medicine physicians. Please initial each line on this form and sign at the bottom.

\_\_\_\_\_ As an Orthopaedic Surgeon and Sports Medicine physician, we are responsible for diagnosis and treatment of immediate orthopaedic related pain and complications.

\_\_\_\_\_ As such, the physicians do NOT prescribe long-term medication prescriptions to their patients.

\_\_\_\_\_ Any long-term medication use, be it narcotic, non-narcotic, or anti-inflammatory, must be obtained through a Primary Care Physician, or other designated provider.

\_\_\_\_\_ In the event surgical intervention is performed, we will ONLY prescribe narcotic pain medication for up to 2 prescriptions post-operatively, dependent upon the procedure.

\_\_\_\_\_ We may prescribe pain medication for severe or complicated fractures.

\_\_\_\_\_ As the patient, please understand medication provided should not be used at a more accelerated rate than originally prescribed, as this may result in being without medication for a period of time should violations occur.

\_\_\_\_\_ I understand that with the use of prescription monitoring software, your physician may verify if pain medication is being administered by any other source while being prescribed one of our physicians.

\_\_\_\_\_ I agree refills of prescriptions must be requested during regular office hours. No refills will be given after hours or on weekends.

\_\_\_\_\_ If a medication will need to be refilled over the weekend, please request the prescription by Thursday.

\_\_\_\_\_ We request at least 24-hour notice for all refill authorizations, so as to ensure arrangements can be made.

I, \_\_\_\_\_, understand these guidelines as described above and agree to follow the policy outlined in this document. I also understand the benefits and risks of the use of an opioid analgesic, including the potential risk of addiction.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



## 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: \_\_\_\_\_



## 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
_____	_____	_____
_____	_____	_____
_____	_____	_____

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: \_\_\_\_\_