Med Rec. #:

Date: _____

WELCOME

Doctor _____

An OrthoTennessee Care Center

1 ABOUT YOU

Patient's Full Name

_____
First MI Last

Street Address _____

Mailing Address _____

City _____ State _____ Zip _____

Email Address _____

Cell Phone # _____

Home Phone # _____

Work Phone # _____

Male Female Birthdate: _____ Age: _____

SSN # _____

Circle: Single Married Divorced Widowed

Employer _____

Employer's Address _____

If Student, School? _____

Race _____ Language _____

Ethnicity _____ **VOLUNTARY

What BODY PART are we seeing you for today? _____

Is your complaint due to **injury** or **onset of pain**? (circle one)

Is your injury or onset of pain on: (circle one) **Right Side** or **Left Side**

Due to: (circle one) Work Auto Accident Other

What date did your illness or injury start? _____

Did this injury occur on the job? _____

If auto accident, state occurred in _____

Full Name of Referring Doctor _____

Full Name of Famiy Doctor _____

Emergency Contract Name _____

Emergency Contact Phone # _____

2 Spouse (or Parent if Minor) Information

Spouse or Parent Name _____

Spouse or Parent DOB _____ Phone # _____

Spouse or Parent Address _____

Spouse or Parent Employer _____ Phone # _____

3 INSURANCE

PRIMARY INSURANCE

Insurance Co. Name _____

Insured's Name _____

Insured's Relation _____

Insured's Address _____

Insured's Birthdate _____

Insured's Employer _____

SECONDARY INSURANCE

Insurance Co. Name _____

Insured's Name _____

Insured's Relation _____

Insured's Address _____

Insured's Birthdate _____

Insured's Employer _____

I authorize consent for treatment, the release of any medical information necessary and authorize payment of medical benefits to OrthoTennessee, for services provided. I authorize OrthoTennessee/MOC, as a part of my medical evaluation and treatment, to access my electronic medication history. I understand that I am financially responsible for the charges covered by this authorization, and for collection expenses on unpaid balances.

SIGNATURE _____ DATE _____

OrthoTennessee

Knoxville Orthopaedic Clinic • Maryville Orthopaedic Clinic • Orthopaedic Surgeons of Oak Ridge • University Orthopaedic Surgeons

MEDICAL HISTORY

Patient's Name _____ Medical Record#_____

Patient's Date of Birth _____ Today's Date_____

Medical History

❑ **None of the following?**

Past	Current		Past	Current	
❑	❑	Anxiety	❑	❑	Hepatitis/Liver disease
❑	❑	Depression	❑	❑	Hypertension/High blood pressure
❑	❑	Bipolar	❑	❑	Myocardial Infarction/Heart attack
❑	❑	Arthritis	❑	❑	Osteoporosis
❑	❑	Asthma	❑	❑	Peptic ulcer disease
❑	❑	Cancer	❑	❑	Renal disease/Kidney disease
❑	❑	Congestive heart failure	❑	❑	Rheumatoid Arthritis
❑	❑	COPD/Emphysema	❑	❑	Seizures
❑	❑	Coronary artery disease/Heart Disease	❑	❑	Sleep apnea
❑	❑	Deep venous thrombosis/Blood clots	❑	❑	Stroke
❑	❑	Diabetes	❑	❑	Thyroid disease
❑	❑	Elevated lipids/High Cholesterol	❑	❑	HIV /Aids
❑	❑	Gout	❑	❑	Pulmonary embolus/Blood clots in lung

❑ Other illnesses currently or chronically treated_____

Past Surgical History - Have you had any of the following surgeries?

❑ **None**

❑ ACL repair __right __left
❑ Angioplasty
❑ Appendectomy
❑ Arthroscopy
❑ Back surgery
❑ Neck surgery
❑ Blood transfusion
❑ CABG/Coronary artery bypass
❑ Cardiac pacemaker
❑ Cardiac valve replacement
❑ Cholecystectomy/gall bladder
❑ Gastric bypass
❑ Hernia repair
❑ Hip replacement __right __left
❑ Knee replacement __right __left
❑ Meniscus surgery/Knee cartilage __right __left
❑ ORIF/Fracture surgery - body part_____
❑ Rotator cuff repair __right __left
❑ Thyroidectomy
❑ Tonsilectomy
❑ Hysterectomy

❑ Other surgery _____

Social History

Do you use tobacco? ❑ Yes ❑ No Amount _____

If no, ❑ never used tobacco ❑ former tobacco user

Do you use alcohol? ❑ Yes ❑ No Amount _____

Family History

Has anybody in your family had any of these conditions?

Blood disorder ❑ Yes ❑ No Family Member_____
Heart disease ❑ Yes ❑ No Family Member_____
Stroke ❑ Yes ❑ No Family Member_____
Cancer ❑ Yes ❑ No Family Member_____
Diabetes ❑ Yes ❑ No Family Member_____

Do you have sleep apnea?	❑ Yes	❑ No
Are you on blood thinners?	❑ Yes	❑ No
Are you pregnant?	❑ Yes	❑ No
Do you have a latex allergy?	❑ Yes	❑ No
Do you have metal allergy?	❑ Yes	❑ No

Immunizations

Have you had a Flu Vaccine in the last 12 mo.? ❑ Yes ❑ No Date _____

Have you had a Pneumonia Vaccine? ❑ Yes ❑ No Date _____

Allergies - List all drugs to which you are allergic:

_____
_____
_____

Type of reaction - Example: Skin rash, Nausea, etc.

_____
_____
_____

❑ **No known allergies**

Medications - Please list all medications you are currently taking including supplements:

_____
_____
_____
_____

❑ **I am not taking any medications at this time.**

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REVIEW OF SYSTEMS

Patient's Name _____ Medical Record#_____

Patient's Date of Birth _____ Today's Date_____

Pharmacy - Please list your desired pharmacy in the event you receive a medication order:

_____

Street and City _____

Review of Systems: Do you have any of the following symptoms?
Please mark **YES** or **NO** for each condition.

CONSTITUTIONAL ❑ Normal

NO	YES	
❑	❑	Fever
❑	❑	Weight gain
❑	❑	Weight loss

HEAD, EYES, EARS, NOSE, THROAT ❑ Normal

NO	YES	
❑	❑	Headache
❑	❑	Hearing loss
❑	❑	Vision loss

RESPIRATORY ❑ Normal

NO	YES	
❑	❑	Cough
❑	❑	Dyspnea/Short of breath
❑	❑	Recent Infections
❑	❑	Wheezing

CARDIOVASCULAR ❑ Normal

NO	YES	
❑	❑	Chest pain
❑	❑	Irregular heartbeat/ palpitations
❑	❑	Poor circulation

GASTROINTESTINAL ❑ Normal

NO	YES	
❑	❑	Abdominal pain
❑	❑	Diarrhea
❑	❑	Vomiting
❑	❑	Reflux

GENITOURINARY ❑ Normal

NO	YES	
❑	❑	Dysuria/painful urination
❑	❑	Hematuria/Bloody urine
❑	❑	Urinary retention/ unable to urinate
❑	❑	Frequent bladder infections

NEUROROLOGICAL ❑ Normal

NO	YES	
❑	❑	Numbness in extremities

PSYCHIATRIC ❑ Normal

NO	YES	
❑	❑	Anxiety
❑	❑	Bipolar
❑	❑	Depression
❑	❑	Claustrophobia

SKIN ❑ Normal

NO	YES	
❑	❑	Rash
❑	❑	Skin infection
❑	❑	Sores that do not heal

MUSCULOSKELETAL

❑ Negative, except today's complaint

HEMATOLOGIC ❑ Normal

NO	YES	
❑	❑	Bleeding disorders

IMMUNOLOGICAL ❑ Normal

NO	YES	
❑	❑	Food allergies
❑	❑	Environmental allergies

Are there any other medical problems that we should be aware of?_____

To the best of my knowledge the above information is current and correct.

Signature: _____ **Date:**_____

Patient Name: _____

Med Rec. #: _____

Date: _____

ORTHOTENNESSEE/MARYVILLE ORTHOPAEDIC CLINIC

Part A. Notice of Financial or Investment Relationship:

In order to provide you with the most comprehensive quality care, you may be referred to a facility (Maryville Surgery Center, OTN Custom Bracing, OTN Imaging) in which your physician may have an ownership interest.

1. This document serves as notice to you of the various investments and/or financial interest of the physicians of OrthoTennessee.

2. You have a right to request services (MRI, orthotics, and surgery centers) at the provider of your choice or request an alternative provider. Please advise your physician and you will be referred to another comparable facility.

3. You will not be treated differently by this practice or by your physician if you choose not to use the services recommended by your physician, in which he/she has a financial/investment interest.

Part B. Patient Privacy Notice Acknowledgement

DESIGNATED REPRESENTATIVES

The following people may call to ask and/or receive medical information for me: (this is not a consent for release of medical records or X-rays). Note: If the patient is a minor please list another adult other than parent that can accompany them to their appointment.

Name of Representatives Relationship

_____

_____

_____

I authorize OrthoTennessee/Maryville Orthopaedic Clinic to leave messages containing my personal health information at the following telephone numbers:

_____ _____

Authorization and acknowledgement of Part A and B of this form

Patient's Name (print) _____ Date _____

Patient's Signature _____

Or Parent, Legal Guardian, Patient Representative

Signature _____

Relationship to Patient _____