

**THE CENTER FOR ORTHOPAEDICS & SPORTS MEDICINE**  
REGISTRATION FORM - (PLEASE PRINT)

John C Sparks, Jr., M.D.,F.A.A.O.S.

**PATIENT INFORMATION**

Patient's Last name:		First:	Middle:	Marital status (check one)	
				<input type="checkbox"/> Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Widow	
Social Security:			Birth date:	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Email Address:			/ /		
Mailing Address:				Home ph: (   )	
City:	State:	Zip:		Cell ph: (   )	
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Student	Employer:	Employer ph:		Work ph: (   ) To which # do you wish to receive appointment reminders?	
Pharmacy's Name			Pharmacy's Ph: (   )		
Pharmacy's Address:					
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic			Race: <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other		
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other					

**INSURANCE INFORMATION**

<u>PRIMARY INSURANCE</u>	<u>SECONDARY INSURANCE</u>
Name of primary insurance: _____	Name of secondary insurance : _____
Subscriber's name: _____	Subscriber's name: _____
Subscriber's S.S.: _____	Subscriber's S.S.: _____
Birth date: _____	Birth date: _____
Group: _____	Group: _____
Policy #: _____	Policy #: _____
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other	Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other

**IN CASE OF EMERGENCY**

Name:	Relationship to patient:	Home ph: (   )
		Work ph: (   )
		Cell ph: (   )

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 my insurance company to release any information required to process my claims. I acknowledge receipt for the notice of privacy policies and practices of this clinic.

<i>Patient/Guardian signature</i>	<i>Date</i>
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## **HIPPA Release Form**

I am aware of the HIPPA Notice and Privacy Practices for The Center for Orthopaedics and Sports Medicine. The copies are available for me to take upon request.

**\*\*\*DISCLAIMER\*\*\***

*The physicians of the Center for Orthopaedics and Sports Medicine, Dr. Sparks, may or may not have financial interest in the following facilities; Conroe Surgery Center, Cornerstone Specialty Hospital-Conroe, Aspire Behavioral Health of Conroe LLC, St. Luke's Lakeside Hospital*

## **Consent for Release of Medical Information**

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to: (Please include their names on the lines provided)

- Spouse \_\_\_\_\_
- Child (ren) \_\_\_\_\_
- Parent(s) \_\_\_\_\_
- Other \_\_\_\_\_

I do not authorize medical care and/or treatments to be discussed with anyone other than myself.

This Release of Information will remain in effect until terminated by me in writing.

## **Messages**

Preferred Contact when trying to reach me:

- Home  Cell  Work

If unable to reach me:

- You may leave a detailed message
- Please leave a message asking me to return your call
- Other \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

THE CENTER FOR ORTHOPAEDICS & SPORTS MEDICINE  
NO SHOW APPOINTMENT AND FORM CHARGE POLICY

At this time we **do not** give appointment reminder calls. Please take advantage of the appointment card offered to you when you schedule your next appointment. If you do not **cancel** or **reschedule** your appointment you will be charged a **NO SHOW** fee of **\$25.00**.

We do charge for the completion of the following forms effective 4/17/2014:

- Short Term Disability
- Long Term Disability
- Family Medical Leave Act (FMLA)
- Attending Physician Statement (AFLAC)

Charges are as follows:

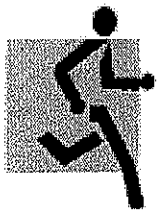
1 page \$15.00

2-5 pages \$25.00

6-10 pages \$40.00

By **signing** this form, you **acknowledge** and **understand** these charges.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Start Here— Use black pen or pencil and mark the ● circles completely. The questions and your answers are for the current problem you are seeing the physician for today unless specifically asked about previous problems.

GENERAL PATIENT INFORMATION

Today's date

Grid for entering today's date

Please print your name.

What is your age and date of birth?

Print numbers in the boxes.

Age Month Day Year

Grid for entering age and date of birth

What is your sex? Mark ● ONE circle

- Male Female

What is your height and weight?

Print numbers in the boxes.

Height: ft. in. Weight: lbs

Grid for entering height and weight

How did you hear about our office?

Mark ● ONE circle.

- ER Physician Friend Internet Newspaper Radio Phone book Other—Print other below.

Who is your family physician?

Print name.

Who is the physician that referred you to our office?

Print name.

HISTORY OF CURRENT PROBLEM

1. What is your primary orthopaedic problem today? Mark ● ONE circle

- Pain Tingling Instability Stiffness Numbness Weakness Swelling Other—Print other below

2. Where is the location of your primary problem? Mark ● ONE circle

- Right side Left side Both sides a. If both sides, which side bothers you the greatest? Right Left

3. What body part is involved with your primary orthopaedic problem?

Mark all that apply

- Neck Upper Back Shoulder Arm Elbow Forearm Wrist Hand Thumb Index Finger Middle Finger Ring Finger Pinky Mid Back Low Back Pelvis Hip Buttocks Thigh Knee Lower Leg Calf Ankle Foot Toe Other—Print other below

4. What is your dominant hand?

- Right Left

5. When was the onset of your current problem?

- Unknown Gradually Suddenly, without injury Suddenly, after an injury or accident Gradually after an injury or accident

6. If after an injury or accident, where did the injury or accident take place?

Mark ● ONE circle

- Home School Sports Motor Vehicle Accident Work related Other—Print other below

a. If your condition is due to an injury or accident answer the question below.

• Date of the injury or accident

Grid for entering date of injury or accident

b. If your condition is related to a work injury or accident answer the questions below.

• Date of work injury or accident

Grid for entering date of work injury or accident

• Date reported to your employer

Grid for entering date reported to employer

CONTINUE on page 2.

7. How did the injury or accident occur?  
Please write complete sentences in the space below.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. Have you been treated for this problem in the Emergency Room?  No  Yes

9. Have you been seen by another physician for this problem?  No  Yes

a. If yes, who was the treating physician?

\_\_\_\_\_

10. Have you received Physical Therapy for this problem?  No  Yes

a. If yes, where did you receive your Physical Therapy treatment?

\_\_\_\_\_

b. How long did you receive Physical Therapy?

- < 1 month  1 month  
 2 months  3-6 months  
 7-12 months  Over 1 year

11. What medications are you taking for this problem?

- Advil  Aleve  Arthrotec  
 Aspirin  Celebrex  Codeine  
 Daypro  Flexeril  Motrin  
 Naprosyn  Percocet  Skelaxin  
 Steroid Inj.  Tylenol  Vicodin  
 Voltaren  Mobic  Lodine  
 Other—Print other below

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

12. In the space provided, list all other medications you are taking including non-prescription medications. Do not include the medications you have previously listed.

None

If you need additional space please write on the back

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

13. Indicate any past testing you've had done for this problem.

- X-rays  MRI  Bone Scan  
 CAT Scan  Discogram  EMG  
 Ultrasound  Lab Tests  
 Other—Print other below

14. Since the onset, what is the status of your symptoms?

- Improved  Worsening  
 No change

15. How long have the symptoms been present?

Mark  ONE circle.  Not sure

- |        |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |
|--------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
|        | 1                     | 2                     | 3                     | 4                     | 5                     | 6                     | 7                     | 8                     | 9                     | 10                    | 11                    |
| Days   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Weeks  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Months | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Years  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

16. On the scale below, mark the severity of your pain, 10 being the highest.

Mark  ONE circle

- |       |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |                       |
|-------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
|       | None                  |                       | Mild                  |                       | Moderate              |                       | Severe                |                       |                       |                       |                       |
|       | 0                     | 1                     | 2                     | 3                     | 4                     | 5                     | 6                     | 7                     | 8                     | 9                     | 10                    |
| Right | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Left  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

17. Symptoms improve with:

- Rest  Activity  Medication  
 Ice/cold  Heat  Walking

18. Symptoms feel worse with:

- Rest  Activity  Sitting  
 Ice/cold  Heat  Walking  
 Climbing Stairs

19. Are the symptoms worse during the day or night?

- No difference  Day  Night

CONTINUE on page 3.

## MEDICAL, PERSONAL, SOCIAL HISTORY

20. Do you have any allergies or reactions?

- No known allergies.  
 Sulfa       Penicillin       Latex  
 Iodine dyes       Anesthesia       Codeine  
 Feathers       Eggs       Animals  
 Adhesive Tape       Environmental

Additional Allergies—Print below

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21. Have you had any surgeries?

- No       Yes

If yes, select from the list below.

- Arthroscopy Knee       Arthroscopy Shoulder  
 Total Knee Replacement       Total Hip Replacement  
 Rotator Cuff Repair       Carpal Tunnel Release  
 Back Surgery       Neck Surgery  
 Appendectomy       Gall Bladder  
 Hysterectomy       Hernia  
 Malignancy       Bowel Surgery

Additional Surgeries—Print below

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22. Indicate past medical conditions.

- No significant medical history  
 Anemia       Asthma  
 Bleeding Disorder       Blood Transfusions  
 BPH/Prostate dis.       Bronchitis  
 Cancer       COPD  
 Coronary Artery dis       Depression  
 Diabetes       Elev. Cholesterol  
 Angina/Arrhythmia       Fibromyalgia  
 GERD       Glaucoma  
 Gout       Hypertension  
 Intestinal Disease       Kidney/Renal Disease  
 Liver dis./Hepatitis       Obesity  
 Osteoarthritis       Osteoporosis  
 Osteomyelitis       Peripheral Vascular  
 Phlebitis       Rheumatoid Arthritis  
 Seizures       Stomach Ulcers  
 Stroke/TIA/CVA       Thyroid Disease

23. Are you claustrophobic?       No       Yes

24. Do you smoke?       No       Yes

25. Indicate your father's medical conditions.

- No medical conditions  
 Arthritis       Cancer       Diabetes  
 Gout       Heart Disease       Stroke  
 TB       Hereditary Defects  
 High blood pressure  
 a. What is your father's health status?  
 Living       Deceased       Unknown

26. Indicate your mother's medical conditions.

- No medical conditions  
 Arthritis       Cancer       Diabetes  
 Gout       Heart Disease       Stroke  
 TB       Hereditary Defects  
 High blood pressure  
 a. What is your mother's health status?  
 Living       Deceased       Unknown

27. Select all problems you have had in the last 6 months?

- Fevers       Sweats  
 Weight gain       Fatigue  
 Weight loss (unexpl.)       Hearing loss  
 Weight loss (planned)       Ringing in ears  
 Vision changes       Hoarseness  
 Trouble swallowing       Sore throat  
 Shortness of breath       Wheezing  
 Chronic cough       Leg cramps  
 High blood pressure       Palpitations  
 Irregular heartbeat       Chest pain  
 Diarrhea       Heartburn  
 Constipation       Nausea  
 Abdominal pain       Fracture  
 Vomiting       Bone pain  
 Other joint pain       Muscle spasms  
 Other muscle pain       Skin ulcers  
 Rashes       Hives  
 Loss of coordination       Weakness  
 Fainting       Numbness  
 Headaches/Migraine       Depression  
 Anxiety       Disoriented  
 Incontinence       Discharge  
 Burning urination       Freq urination  
 Difficulty urinating       Bleeding

Please sign and date this form

Signature \_\_\_\_\_

Date \_\_\_\_\_



Please return your completed form to the front desk.