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)**
			❑Single ❑ Mar ❑ Div ❑Sep ❑ Widow

Social Security:	**Birth date:**	**Age:**	**Sex:** ❑ Male ❑ Female
Email Address:	/ /		

Mailing Address:			**Home ph: ( )**
City:	**State:**	**Zip:**	**Cell ph: ( )**
Employment Status: ❑ Full Time ❑ Part Time ❑ Retired ❑ 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: ____ Hispanic ____ Non Hispanic | **Race:** ___ White ___ African American ___ Asian ___ Hispanic ___ Pacific Islander ___ Other

Language: ___ English __ Spanish __ Other

INSURANCE INFORMATION

PRIMARY INSURANCE	**SECONDARY INSURANCE**
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: ❑ Self ❑ Child ❑ Spouse ❑ Other	Patient's relationship to subscriber: ❑ Self ❑ Child ❑ Spouse ❑ 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.

Patient/Guardian signature	***Date***

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:

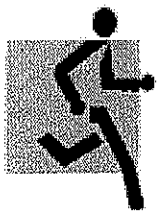
- Short Term Disability
- Long Term Disability
- Family Medical Leave Act (FMLA)
- Attending Physician Statement (AFLAC)

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: _____



The Center for Orthpaedics & Sports Medicine

JOHN SPARKS, JR. M.D. F.A.A.O.S

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

Please print your name.

What is your age and date of birth?
Print numbers in the boxes.
Age Month Day Year

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

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

b. If your condition is related to a work injury or accident answer the questions below.
• Date of work injury or accident
• Date reported to your 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	○	○	○	○	○	○					
Weeks	○	○	○	○							
Months	○	○	○	○	○	○	○	○	○	○	○
Years	○	○	○	○	○	○	○	○	○	○	○

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	○	○	○	○	○	○	○	○	○	○	○
Left	○	○	○	○	○	○	○	○	○	○	○

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

_____

_____

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

_____

_____

_____

_____

_____

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

STOP Please return your completed form to the front desk.