Name: Sports Medicine Joint Replacement Specialists, Corp. O South Hills
DOB: Dr. Gregory F, Habib O Greensburg

DEMOGRAPHIC INFORMATION		
Patient Name (print first, middle and last below)	DOB: SS#	
	Marital Status:	
Street Address:		
City, State, Zip:		Gender: O Male O Female
Home Phone:	Cell Phone:	Emergency Contact Phone:
		Name:
Leave message: O Y O N	Leave message: O Y O N	Relation:
Patient email address:		
Race: O White O Hispanic O Black O Other:_____		O Declined to Specify
Ethnicity: Latino O Y O N	Language Spoken:	Interpreter required O Y O N
Spouse's Name:	DOB:	SS#: Employer:
Primary Care Physician:		Referring Physician:
Primary Care Physician Ph#:		Referring Physician Ph#:
Are you currently under contract with Pain Management? O Y O N		
*If yes, Physician Name and Ph#:		
Complete this section ONLY if patient is a minor (under 18) or has a legal guardian		
Primary Legal Gauardian Name:	Date of Birth:	Phone:
Secondary Legal Gaurdian Name:	Date of Birth:	Phone:
Street Address, City, ST & ZIP: Only if different from patient's address		
****Complete this section if Auto-accident or Workers Compensation Insurance applies****		
Employment Information		
Injured on the job? O Yes O No		Currently working? O Yes O No
Auto Accident? O Yes O No		Date Last Worked:
Liability Claim? O Yes O No		Job Description:
Seeking Disability? O Yes O No		Employer Name:
Attorney Name:		Employer Address:
Attorney Ph#:		
*****Complete this section ONLY if covered by multiple insurance plans*****		
Primary Medical Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:
Policy Holder's Name:		Policy Holder's DOB:
Pharmacy Insurance Plan Information		
Plan Name:	Policy #:	
	Group #:	
Pharmacy Information		
Pharmacy Name, Street, City, State:		
Pharmacy Phone Number:		

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Medications, stregnth and dosage **include Over-The-Counter, Vitamins and Herbal Remedies		
O No Medications reported	4)	8)
1)	5)	9)
2)	6)	10)
3)	7)	11)

Allergies		
O No Known Drug Allergies	3)	6)
1)	4)	7)
2)	5)	8)

Social History / Habits

Smoking Status O Yes O No Packs per day_____ Date quit smoking:_____
Other tobacco use O Yes O No If yes,describe:_____
Alcohol Comsuption O Yes O No How often_____ Alcoholism O Yes O No
Illegal Drug Use O Yes O No If yes, describe:

Family History

	Mother	Father	Grandparent	Sibling	Child
Arthritis	O Y O N	O Y O N	O Y O N	O Y O N	O Y O N
Cancer	O Y O N	O Y O N	O Y O N	O Y O N	O Y O N
Diabetes	O Y O N	O Y O N	O Y O N	O Y O N	O Y O N

Medical Problems / History

O No medical problems reported		O Tuberculosis	O Depression	O Metal Implants
O DVT/ blood clots	O Kidney problems	O Bronchitis	O Dementia	(specify location):
O Diabetes	O Heart Attack	O Asthma	O Parkinsons Disease	
O Osteoporosis	O Stroke	O COPD / Emphysema	O Epilepsy / Seizures	
O Gastric Ulcer	O Heart Disease	O High Blood Pressure	O Rheumatoid Arthritis	
O GERD	O Heart murmur	O High Cholesterol	O Anemia	
O Hernia	O Heart Failure	O HIV / AIDS	O Liver Disease	O Pacemaker
O Fibromyalgia	O Irregular Heart Beat	O Kidney Stones	O Poor Circulation	implatation date:
O Gout	O Pneumonia	O Kidney Disease	O Cancer	
O Osteoarthritis	O Sleep Apnea	O Colitis	O Substance Use	
O RSD	O Thyroid disorder	O Hepatitis (specify):	O Easy Bleeding	
O Lyme Disease	describe:	Type: A B C	O Other (specify)	

Surgical History

O No surgical history reported	O Knee Arthroscopy	O Hip Replacement	O Prostate Surgery
O Hemorrhoidectomy	O Appendectomy	O Knee Placement	O Gastric Bypass
O Gallbladder Surgery	O Thyroid Surgery	O Hernia Repair	O Back Surgery
O Rotator Cuff Repair	O Cataract Surgery	O Heart Bypass	

O Women only: Hysterectomy / Tubal ligation
O Tonsillectomy with Anenoidectomy
O Metal Implants (Specify location)

Social History

O Right Handed O Left Handed Live in a: O Single Level Home O Multi Level Home
O Retired O On Disability O Unemployed O Occupation (specify)
Height:_____ft _____in Weight:_____lbs
List any hobbies/sports that you enjoy:

List any activities you are currently unable to perform:

Name:
DOB:

Sports Medicine Joint Replacement Specialists, Corp.
Dr. Gregory F, Habib

O South Hills
O Greensburg

Injury Information / Reason for today's visit Date: _____

Affected Body Parts:

Describe How Injury Occurred:

Current Medical Status

Constitutional	Neurological Symptoms	Skin Symptoms
O Yes O No Weight Change	O Yes O No Dizziness	O Yes O No Tattoo
O Yes O No Interruption of sleep	O Yes O No Fainting	O Yes O No skin rash
O Yes O No Abnormal Fatigue	O Yes O No tingling	O Yes O No Surigcal Scar
O Yes O No Fever	O Yes O No numbness	O Yes O No yellow skin or eyes
Other:	Other:	Other:

Cardiovascular	Genitourinary	Pulmonary
O Yes O No High Blood Pressure	O Yes O No Blood in urine	O Yes O No Sleep Apena
O Yes O No High Cholesterol	O Yes O No Painful urination	O Yes O No Asthma
O Yes O No Chest Pain	O Yes O No Increased urinary frequency	O Yes O No COPD
Other:	Other:	Other:

Psychological Symptoms	Endocrine Symptoms	Hematological/Blood
O Yes O No Anxiety	O Yes O No Diabetes	O Yes O No Clotting disorder
O Yes O No Depression	O Yes O No Thyroid disease	O Yes O No Anemia
Other:	Other:	Other:

HEENT	Gastriontestinal	Other Not listed:
O Yes O No Hearing loss	O Yes O No Heartburn/GERD	
O Yes O No Dentures currently	O Yes O No Nausea / Vomitting	
O Yes O No Corrective Lenses	O Yes O No Diarrhea	
Other:	Other:	

Musculoskeletal Review of Symptoms

Date of Onset:_____ Has been going on for:_____days _____wks _____mos. _____yrs

How did this problem start? (pick one) O No Injury: Onset was O gradual O sudden

O Auto Accident O Injury (where did it happen)_____

Body Part involved:

Shoulder	O Right O Left	Arm	O Right O Left	Elbow	O Right O Left	Wrist	O Right O Left	Hand	O Right O Left
Pelvis	O Right O Left	Hip	O Right O Left	Knee	O Right O Left	Leg	O Right O Left	Ankle / Foot	O Right O Left
Neck	Radiating to	O R Arm O L Arm O Neither	Back	Radiating to	O R Arm O L Arm O Neither	Finger 2 3 4 5	T O Right O Left	Toe B 2 3 4 5	O Right O Left

Pain Severity on a scale of 1 to 10; 10= worst Worst:_____ Best_____

Pain Quality: O Sharp O Stabbing O Throbbing O Burning O Aching O Dull O Other_____

Pain Frequency: O Intermittent O Constant O Activity related O Worse in AM O Worse in PM

Does the pain wake you from sleep? O Yes O No

Do you have? O Swelling O Bruising O Numbness O Tingling

Is this problem getting: O Better O Worse O No Change

What makes symptoms Better? O Bracing O Elevation O Heat O Ice O Injections O Medications O Rest

What makes symptoms Worse? O Bending O Climbing Stairs O Exercise O Kneeling O Lifting the body part

O Running O Sitting O Squating O Standing O Twisting O Walking O Other_____

Previous Treatments for this problem:

O Bracing O Medications O Physical Therapy O Injections O Surgery O Chiropractor O Cane/Crutch

O Other: _____

Consent to Treatment and Payment Authorization

I hereby give my consent to the physicians and other clinical personnel of for Sports Medicine & Joint Replacement Specialists, Corp. for the evaluation and treatment of the conditions for which I present in their offices.

I hereby authorize the office of Sports Medicine & Joint Replacement Specialists, Corp. to release any medical information required to permit payment directly to them for services rendered.

I authorize Sports Medicine & Joint Replacement Specialists, Corp. to release information related to my condition to the applicable worker's compensation carrier, auto insurance carrier, or my personal health insurance carriers as necessary based on the type and place of injury.

I recognize and accept the responsibility for services rendered regardless of insurance coverage; including but is not limited to, co-insurance, co-payment, deductible and non-covered services.

Sports Medicine & Joint Replacement Specialists Corp. will not accept any attorney's letter of protection. All charges for my care are ultimately my responsibility to pay in full, within 60 days of services rendered.

Patient Consent for Use and Disclosure of Protected Health Information

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication.
You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO

If YES, please name the family members allowed: _____
_____

Patient Name: (Printed)_____Signature:_____

(if not the patient If not the patient state your relationship to patient :_____

Today's Date:_____