ORTHOPEDIC & SPORTS
ENHANCEMENT CENTER
An Affiliate of
Advocate BroMenn

2406 East Empire Bloomington, Illinois 61704 (309) 663-9300

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PATIENT INFORMATION RECORD (please print or write legibly)

PATIENT'S NAME				TODAY'S DATE	HOME PHONE NUMBER (INCLUDE AREA CODE)
MARITAL STATUS S M W D SEP	DATE OF BIRTH	AGE	SEX M F	EMAIL	CELLULAR PHONE
STREET ADDRESS (PERMANENT)				CITY AND STATE / ZIP CODE	SOCIAL SECUIRITY NUMBER ____ ____
PATIENT'S EMPLOYER NAME					
ADDRESS				CITY AND STATE / ZIP CODE	PHONE NUMBER (INCLUDE AREA CODE)
SPOUSE'S NAME				SOCIAL SECURITY NUMBER	SPOUSE'S DATE OF BIRTH
SPOUSE'S EMPLOYER NAME					
ADDRESS				CITY AND STATE	PHONE NUMBER (INCLUDE AREA CODE)
EMERGENCY CONTACT (NAME AND PHONE NUMBER)					

ARE YOU COLLECTING SOCIAL SECURITY DISABILITY? ☐YES ☐NO	SOCIAL SECURITY START DATE _____ / _____ / _____
CURRENT WORK STATUS: ☐WORKING ☐ DISABLED ☐ UNEMPLOYED ☐ RETIRED ☐SICK LEAVE	WORK RESTRICTIONS? ☐YES ☐ NO
WHAT TYPE OF WORK DO YOU DO?	DOES YOUR JOB CONTRIBUTE TO YOUR PAIN? ☐ YES ☐ NO

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT)

WIFE/MOTHER'S NAME	STREET ADDRESS, CITY, STATE, AND ZIP CODE	HOME PHONE NO. & AREA CODE
WIFE/MOTHER'S SOCIAL SECURITY NO.	WIFE/MOTHER DATE OF BIRTH	
WIFE/MOTHER'S EMPLOYER	OCCUPATION	BUSINESS PHONE NO. & AREA CODE
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE
HUSBAND/FATHER'S NAME	STREET ADDRESS, CITY, STATE, AND ZIP CODE	HOME PHONE NO. & AREA CODE
HUSBAND/FATHER'S SOCIAL SECURITY NO.	HUSBAND/FATHER'S DATE OF BIRTH	
HUSBAND/FATHER'S EMPLOYER	OCCUPATION	BUSINESS PHONE NO. & AREA CODE
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE

NAME OF HOSPITAL OR PHYSICIAN WHO REFERRED YOU TO OUR PRACTICE		
FAMILY PHYSICIAIN (FIRST AND LAST NAME)	STREET ADDRESS	CITY, STATE, AND ZIP CODE
WHICH PHYSICIAN IN OUR PRACTICE ARE YOU SEEING TODAY? ☐ DR. DUSTMAN ☐ DR. SEIDL ☐ DR. DANGLES ☐ DR. NORRIS ☐ DR. DUHIG ☐ DR. PAUL ☐BRAD COLE ☐JEFF WILLIAMSON		
HAVE YOU EVER BEEN TREATED BY ANY OTHER PHYSICIAN AT SPORTS ENHANCEMENT CENTER, LLC?		
IF SO, WHO AND WHAT YEAR?		

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY (MEDICARE, IDPA, SELF EMPLOYED, PRIVATE, ETC.)		
ADDRESS	GROUP NUMBER	POLICY NUMBER
SECONDARY INSURANCE COMPANY (MEDICARE, IPDA, SELF EMPLOYED, PRIVATE, ETC.)		
ADDRESS	GROUP NUMBER	POLICY NUMBER

IS THIS A **WORK INJURY?** ☐ YES ☐ NO	**WORKMAN'S COMPENSATION INSURANCE CO.** NAME
WORK COMP INSURANCE ADDRESS	ADJUSTOR'S NAME
CLAIM #	PHONE#

IS THIS A **LIABILITY CLAIM** (I.E. CAR ACCIDENT)? ☐ YES ☐ NO	
LIABILITY INSURANCE NAME:	CLAIM#
LIABILITY INSURANCE ADDRESS	
POLICY HOLDER NAME FIRST: LAST	DATE OF BIRTH
POLICY HOLDER ADDRESS	
INSURANCE CONTACT PERSON? NAME:	PHONE#

DID AN **INJURY** CAUSE OR AGGRAVATE YOUR PROBLEM? CAUSED AGGRAVATED NO INJURY

WHEN WAS THE FIRST OR MOST SERIOUS INJURY?____________________

PLEASE DESCRIBE THE INJURY, YOUR MAIN SYMPTOM (INDICATE LEFT OR RIGHT) ____________________

PLEASE READ AND SIGN THE FOLLOWING:

I hereby give my consent to Sports Enhancement Center to use or disclose, for the purpose of carrying out treatment, payment, or health care operation, all information contained in the above patient record. I acknowledge receipt of the physicians's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved the right to change his privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

It is the insured's responsibility to contact their insurance company to obtain pre-approval, if required, by their insurance company for services rendered and to contact Sports Enhancement Center as to what their policy covers. The insured understands and agrees to pay for any charges incurred that have not been paid by their insurance company, including co-pays, deductibles, and all non-covered items beyond required write-offs. The insured further understands and agrees to pay any attorney and/or collection fees in the event that the account is referred on for collection.

SIGNATURE ____________________ **DATE** ____________________

IF YOU ARE NOT THE PATIENT, PLEASE SPECIFY YOUR RELATIONSHIP TO THE PATIENT ____________________

NEW PATIENT/ NEW PROBLEM HISTORY FORM

This is a confidential record and will be kept in our office. Information contained here will not be released to anyone without your authorization to do so.

NAME, (LAST, FIRST, MI)	TODAY'S DATE
DATE OF BIRTH	REFERRING PHYSICIAN

HISTORY OF PRESENT COMPLAINT: APPROXIMATE HEIGHT______ WEIGHT_______

WHY ARE YOU HERE TODAY?

SEVERITY OF PAIN: (NONE) 0 1 2 3 4 5 6 7 8 9 10 (WORST MANAGABLE)

PROBLEM FIRST NOTICED WHEN:

WHAT MAKES IT WORSE OR BETTER?

HOW LONG DOES IT LAST?

HAVE YOU HAD RECENT X-RAYS? ☐ YES ☐ NO | IF SO, WHERE WERE THEY TAKEN?

ARE YOU CURRENTLY BEING TREATED FOR THIS ILLNESS/INJURY BY ANOTHER PHYSICIAN? ☐ YES ☐ NO

IF YES, WHAT TREATMENT HAS BEEN DONE? (MEDS, THERAPY, ETC.)

MEDICAL HISTORY

MEDICAL PROBLEMS: LIST ALL YOU HAVE/HAVE HAD: (DIABETES, HYPERTENSION, CANCER, GLAUCOMA, HEART ATTACK, BLOOD CLOTS, ETC.)

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____

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______________________________ ☐ NONE

MEDICATIONS:

LIST PRESCRIPTIONS, OVER THE COUNTER MEDS AND HERBAL REMEDIES:

______________ ______________

______________ ______________

______________ ______________

______________ ______________

______________ ______________

MIGHT YOU BE PREGNANT? ☐ YES ☐ NO

LIST ALL SURGERIES WITH APPROXIMATE DATES:

____

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______________________________ ☐ NONE

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATIONS, LATEX, RUBBER, OR X-RAY CONTRAST? ☐ YES ☐ NO
IF YES, PLEASE LIST ALLERGY (INCLUDING TYPE OF REACTION):

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____

____

DO YOU DRINK ALCOHOLIC BEVERAGES? ☐ YES ☐ NO
DO YOU SMOKE? ☐ YES ☐ NO IF SO, HOW MANY PACKS? _____
HAVE YOU EVER SMOKED? ☐ YES ☐ NO IF SO, HOW MANY PACKS? _____
IF YES, WHEN DID YOU QUIT? ______________

FAMILY HISTORY

LIST ANY SIGNIFICANT FAMILY HISTORY (DIABETES, HEART DISEASE, CANCER, HYPERTENSION, BLOOD CLOTS, ETC.)

____

______________________________ ☐ NONE

REVIEW OF SYSTEMS:

CONSTITUTIONAL: Do you have fever, chills, headache, general tiredness, or weakness?	☐ YES	☐ NO
INTEGUMENTARY: Do you habe any skin rashes, persistent itching orother skin problems?	☐ YES	☐ NO
EYES: Do you have any blurred vision, double vision, blind spots, glaucoma, or eye pain?	☐ YES	☐ NO
ENT: Do you have any chronic or persistent ear, sinus, or throat infections or problems?	☐ YES	☐ NO
CARDIOVASCULAR: Do you have any history of chest pain/angina, high blood pressure,or heart murmurs?	☐ YES	☐ NO
PULMONARY: Do you have any history of persistent cough, wheezing, shortness of breath, or pneumonia?	☐ YES	☐ NO
GASTROINTESTINAL: Do you have any chronic nausea, vomitting, indigestion, heartburn, or stomach pains?	☐ YES	☐ NO
MUSCULOSKELETAL: Do you have any history of back, neck or joint pain or injury?	☐ YES	☐ NO
NEUROLOGICAL: Do you have any history of tremors, dizzy spells, numbness, or tingling?	☐ YES	☐ NO
ENDOCRINE: Do you have any history of excessive thirst, weight loss/gain, or too hot/too cold?	☐ YES	☐ NO
HEMATOLOGICAL: Do you have any history of swollen glands, excessive bleeding, or blood clots?	☐ YES	☐ NO
PSYCHOLOGICAL: Do you have any history of depression, anxiety attacks, or suidical thoughts?	☐ YES	☐ NO

PROVIDER'S NOTES:

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DATE: ______________ PROVIDER'S SIGNATURE: ______________________

Notice of Privacy Practices

By signing below, I hereby acknowledge that I have been offered/received a copy of Sports Enhancement Center's Notice of Privacy Practices, effective April 14, 2003.

As of 7/01/2008, if we need to contact you for medical reasons we will utilize all numbers provided unless you follow the protocol as described per our notice of privacy practices (page 5, item 4 of Your Rights):

> "You have the right to ask that we inform you of medical matters in a certain way or at a certain location. To ask for private communications, you must provide a written request and inform us how or where you wish to be contacted. You do not need to inform us as to why. We will try to honor all reasonable requests, For example, you may request we only contact you via work or through mail."

The above policy supersedes all prior forms regarding communication as the policy has been in effect since April 14, 2003.

Signature:_______________________________________ Date:______________________

Printed Name:____________________________________

Please provide us with phone numbers we may use to contact you. If you wish for us to leave messages on an automated system or with others, please indicate to whom we can speak with.

Phone number/s ___________________,______________________,______________________

Person's with whom we may leave messages:____

____

May we leave messages on voice mail? Yes____ No____