CAPSTONE
ORTHOPEDICS & SPORTS MEDICINE

Tel 620-259-2325
Fax 620-259-2337
1818 E 23rd Avenue Suite 1, Hutchinson, KS 67502

Patient Name : ______________________ ____ ______________________ SS# : ______________
(First) (MI) (Last)
Date of Birth: ______________ Sex: ______ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Home Address: ______________________________ P.O. Box: ______________
City: ______________________________ State: ____________ Zip Code: ____________
Home Phone: ( )______________ Cell: ( )______________ Email: ______________
Employer: ______________________________ Work Phone: ( )______________
Spouse Name: ______________ Spouse DOB: __________ Spouse Phone: ( )______________
Emergency Contact: ______________________ Relationship: __________ Phone: ( )______________
Primary Physician: ______________________ Referring Physician: ______________________
Pharmacy & Location: ______________________________ Phone: ( )______________
I give permission for Capstone Orthopedics & Sports Medicine to contact the patient's pharmacy for a list of medications: ☐ Yes ☐ No
Race: ☐ Hispanic ☐ Asian ☐ Caucasian ☐ Black/African American ☐ American Indian or Alaskan Native ☐ Other: __________
Preferred Language: ☐ English ☐ Spanish ☐ Other: ______________
Ethnicity (Nationality-cultural background): ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other: __________

-Person Responsible for Payment of Account-

Name: ______________________________ Relationship: ______________________
Address: ______________________________ Home Phone: ( ) ______________________
City, State, Zip: ______________________________ Other Phone: ( ) ______________________

-Insurance Information-

Please Present Card(s) for Copying. Complete this section only of you do not have your insurance cards.

Primary Insurance: ______________ Policy #: ______________ Group #: ______________
Ins. Address: ______________________________ Ins. Phone: ______________
Policy Holder Name: ______________________ DOB: __________ SS#: ______________
Policy Holder Address: ______________________ City, State, Zip: ______________
Secondary Insurance: ______________ Policy #: ______________ Group #: ______________
Ins. Address: ______________________________ Ins. Phone: ______________
Policy Holder Name: ______________________ DOB: __________ SS#: ______________
Policy Holder Address: ______________________ City, State, Zip: ______________
Other Insurance: ______________ Policy #: ______________ Group #: ______________
Ins. Address: ______________________________ Ins. Phone: ______________
Policy Holder Name: ______________________ DOB: __________ SS#: ______________
Police Holder Address: ______________________ City, State, Zip: ______________

-Complete if Student or Under the age of 18-

Father Information	Mother Information
Name: ______________________	Name: ______________________
Home Phone: ( ) ______________	Home Phone: ( ) ______________
Work Phone: ( ) ______________	Work Phone: ( ) ______________
SS#: ______________ DOB: ______________	SS#: ______________ DOB: ______________

I hereby give my consent to Capstone Orthopedics & Sports Medicine and its business associates to use and disclose my protected health information for the purpose of treatment, payment, and health care operations as noted in the Notice of Privacy Policies provided to me by the practice. I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full. If Capstone Orthopedics & Sports Medicine chooses to accept assignment of my health insurance benefits, I hereby assign all payments to which I am entitled. I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I take full responsibility for all costs incurred by my failure to pay for services rendered.

Signature of Patient or Patient's Representative: ______________________________ **Date:** ______________

Patient: DOB:

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-Authorization for Medical Care-

I hereby authorize Capstone Orthopedics & Sports Medicine to provide me medical treatment for any and all conditions they deem appropriate. I understand the physician or other provider will review the recommendations for testing and/or treatment they deem appropriate for my medical needs based on their professional judgement.

-Referral Waiver-

I acknowledge in the course of my treatment, Capstone Orthopedics & Sports Medicine, may refer me to other health care facilities and/or providers for diagnostic tests, treatment, or consultation. Capstone Orthopedics & Sports Medicine will notify me when such a referral occurs. Capstone Orthopedics & Sports Medicine assumes no responsibility for knowing if the facility or provider I am referred to is contracted with my insurance plan. Should Capstone Orthopedics and Sports & Medicine make such a referral, it is my responsibility to verify my insurance coverage, eligibility, pre-certification (if applicable), and whether the facility or provider I am referred to contracts with my insurance company. Capstone Orthopedics & Sports Medicine is not responsible should my insurance process claims at the non-contracting level for the referred service(s).

-Communication Preferences-

By signing below, *I give permission to the person(s) listed to receive LIMITED information about my care.* I understand my healthcare provider will utilize their professional judgement to ensure that information is shared with family/friends in order to assist with my continuing care. Any request for information not directly relevant to participation in care and any requests for copies of medical records will require a signed HIPAA complaint authorization. This permission will be considered valid for one year unless otherwise revoked in writing.

Note: If you want to give an individual more access to your health information than offered below, you must complete a valid authorization form stating in detail the nature of the information you want released (see receptionist).

Please indicate your preferences below:

1. ☐ Do NOT share ANY information with anyone.
2. Please identify below individual(s) you would like us to share information with and mark the appropriate boxes regarding the type(s) of information we can share with each respective individual(s).

Name: ____________________ Relationship: ____________________

☐ Appointment Dates and Times ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

Name: ____________________ Relationship: ____________________

☐ Appointment Dates and Times ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

Physicians/Providers:

☐ You may also share information, including medical records, with the following physicians/providers who participate in my care:

Name: ____________________ Name: ____________________

College or High School Athletic Department: ____________________

☐ Appointment Dates and Times ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

____________________ ____________________ ____________

Signature of Patient or Personal Representative **Printed Name** **Date**

If Personal Representative, relationship to patient: ____________________

Patient: DOB:

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Chief Complaint

Dominant Hand: ☐ Right Hand ☐ Left Hand ☐ Ambidextrous

Description of the symptoms: ☐ Pain ☐ Numbness/Tingling ☐ Fracture ☐ Stiffness Other: ________________

Shoulder:	☐ Right ☐ Left	Pelvis:	☐ Right ☐ Left	Neck:	☐
Upper Arm:	☐ Right ☐ Left	Hip:	☐ Right ☐ Left	Upper Back:	☐
Elbow:	☐ Right ☐ Left	Thigh:	☐ Right ☐ Left	Mid Back:	☐
Forearm:	☐ Right ☐ Left	Knee:	☐ Right ☐ Left	Low Back:	☐
Wrist:	☐ Right ☐ Left	Lower Leg:	☐ Right ☐ Left	Buttocks:	☐
Hand:	☐ Right ☐ Left	Ankle:	☐ Right ☐ Left	Tail Bone:	☐
Thumb:	☐ Right ☐ Left	Foot:	☐ Right ☐ Left		
Index Finger:	☐ Right ☐ Left	Great Toe:	☐ Right ☐ Left		
Middle Finger:	☐ Right ☐ Left	2nd Toe:	☐ Right ☐ Left		
Ring Finger:	☐ Right ☐ Left	3rd Toe:	☐ Right ☐ Left		
Small Finger:	☐ Right ☐ Left	4th Toe:	☐ Right ☐ Left	5th Toe:	☐ Right ☐ Left

History of Present Illness

1. **How did the symptoms start?** ☐ Acute (Sudden) ☐ Chronic Condition (Gradual Onset)
   When did the symptoms start? (ex: 2 days, 4 months, or an exact date): ______________________________
2. **Is your problem the result of an injury or accident?** ☐ Yes ☐ No
   ☐ Injury at Work ☐ Auto Accident ☐ Sports Injury ☐ Prior Surgery ☐ Other Injury
   Injury Date (ex: mm/dd/yyyy): ____________________
   Brief description of the injury: ____
3. **Are you represented by an attorney?** ☐ Yes ☐ No
4. **Have you had a problem like this before?** ☐ Yes ☐ No
5. **Rate the pain (10 being the most pain).** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
6. **Do the symptoms wake you from sleep?** ☐ Yes ☐ No
7. **Please describe the symptoms.** ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Shooting
8. **What is the timing of the symptoms?** ☐ Constant ☐ Intermittent (comes & goes)
9. **Is the problem getting better or worse?** ☐ Getting Better ☐ Getting Worse ☐ Unchanged
10. **What makes the symptoms worse?**
    ☐ Squatting ☐ Kneeling ☐ Sitting ☐ Bending ☐ Stairs ☐ Lying in Bed ☐ Moving ☐ Twisting
    ☐ Running ☐ Walking ☐ Athletics ☐ Standing ☐ Gripping ☐ Lifting ☐ Reaching Overhead
11. **Are there any other symptoms associated to this problem?**
    ☐ Redness ☐ Bruising ☐ Swelling ☐ Numbness ☐ Stiffness ☐ Limping ☐ Clicking
    ☐ Locking ☐ Popping ☐ Tingling ☐ Weakness ☐ Giving Way
12. **Have you been seen in ER for this problem?** ☐ Yes ☐ No
    Treating ER: (ex. St. Luke's Health) ______________. Date seen: ________________
13. **Have you had prior treatment by another provider?** ☐ Yes ☐ No Physician's name: ____________________
14. **Have you had any prior testing for this problem?**
    ☐ None ☐ X-rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ Nerve Test (EMG)

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15. Prior Treatments:
☐ Ice ☐ Heat ☐ Rest ☐ NSAIDs ☐ Muscle Relaxers ☐ Chiropractor ☐ Physical Therapy ☐ Surgery
☐ Home Exercise Program ☐ Injections ☐ Bracing ☐ Tens Unit ☐ Other/Comments: ____________________.

Medical History

Select any problems you currently have or have had in the past. ☐ **NONE OF THESE APPLY TO ME**

☐ Aids/HIV	☐ Congestive Heart Failure	☐ Gout	☐ Heart Attack: year______
☐ Alcoholism	☐ COPD	☐ Hepatitis: Type____	☐ Rheumatoid Arthritis
☐ Anemia	☐ Coronary Artery Disease	☐ High Cholesterol	☐ Seizure disorder
☐ Arthritis	☐ Depression	☐ Hypertension	☐ Sleep Apnea
☐ Asthma	☐ Diabetes	☐ Lupus	☐ Inflammatory Bowel Disease
☐ Atrial Fibrillation	☐ Drug Abuse	☐ Kidney Disease	☐ Stomach Ulcer
☐ Cancer: Type____________	☐ Blood Clot/DVT	☐ Liver Disease	☐ Thyroid Problems
☐ Stroke	☐ GERD	☐ Osteoporosis	☐ Other:________________

Past Surgical History

Select all previous hospitalizations/surgeries: ☐ None

		Orthopedic Surgery:	**Right**	**Left**
☐ Aneurysm	☐ Hysterectomy	Knee Arthroscopy:	☐	☐
☐ Aortic Bypass/ Vascular	☐ LAP Band / Gastric Bypass	Shoulder Arthroscopy:	☐	☐
☐ Appendectomy	☐ Lumpectomy	Carpal Tunnel Release:	☐	☐
☐ Cataract (Eye) Surgery	☐ Mastectomy	Rotator Cuff Repair:	☐	☐
☐ Cancer/Malignancy	☐ Cholecystectomy (Gallbladder)	Total Hip Replacement:	☐	☐
☐ Heart Surgery	☐ Stents	Total Knee Replacement:	☐	☐
☐ Hernia Repair	☐ Tonsillectomy	Total Shoulder Replacement:	☐	☐

Other Surgery: ____

Spinal (Back) Surgery-Indicate Level: ____________

Family History

Have any direct relatives had any of the following disorders? ☐ None for all

Father:	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension	☐ Bleeding Problems
	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy	☐ Stroke	☐ Osteoporosis
	☐ Cancer	☐ Rheumatoid Arthritis	☐ Unknown		
Mother:	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension	☐ Bleeding Problems
	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy	☐ Stroke	☐ Osteoporosis
	☐ Cancer	☐ Rheumatoid Arthritis	☐ Unknown		
Sibling:	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension	☐ Bleeding Problems
	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy	☐ Stroke	☐ Osteoporosis
	☐ Cancer	☐ Rheumatoid Arthritis	☐ Unknown		

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Social History

1. **Do you some tobacco?** ☐ Current smoker ☐ Former ☐ Never ☐ Smokeless Tobacco ☐ Recreational Drug Use
2. **Do you drink alcohol?** ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never ☐ Former
3. **Martial History:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership
4. **Employment Status?** ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months: ☐ None for all

					None
1)	**CON**	☐ Weight Loss	☐ Loss of Appetite	☐ Fatigue	☐
2)	**EYE**	☐ Blurred Vision	☐ Double Vision	☐ Vision Loss	☐
3)	**ENT**	☐ Hearing Loss	☐ Hoarseness	☐ Trouble Swallowing	☐
4)	**CARDIO**	☐ Chest Pain	☐ Palpitations		☐
5)	**RESP**	☐ Chronic Cough	☐ Pneumonia	☐ Shortness of Breath	☐
6)	**GI**	☐ Heartburn, Ulcers	☐ Nausea, Vomiting	☐ Blood in Stool	☐
7)	**GU**	☐ Painful Urination	☐ Blood in Urine	☐ Kidney Problems	☐
8)	**SKIN**	☐ Frequent Rashes	☐ Skin Ulcers	☐ Lumps ☐ Psoriasis	☐
9)	**NEURO**	☐ Frequent Falls	☐ Loss of Coordination	☐ Numbness	☐
		☐ Change in Bowel	☐ Change in Bladder	☐ Dizziness	
10)	**PSYCH**	☐ Depression/Anxiety	☐ Drug/Alcohol Addiction	☐ Sleep Disorder	☐
11)	**ENDO**	☐ Fever	☐ Heat or Cold Intolerance	☐ Night Sweats	☐
12)	**HEM**	☐ Easy Bleeding	☐ Easy Bruising	☐ Anemia	☐

Medications

Please provide a current list of your medications if available.

Name	Dose/Strength	Frequency

Allergies

☐ Sulfa Allergy ☐ Penicillin Allergy ☐ Latex Allergy ☐ Iodine/Dye Allergy

Do you have any other medication allergies? ☐ Yes ☐ No If yes, list below with the reaction to the allergy:

____

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