Cape Cod Orthopaedics & Sports Medicine, P.C.

130 North Street, Hyannis, MA 02601

Patient Information (Please Print)

Today's Date ______________

Last Name: __________________________ First Name: ________________________________

Middle Initial: _______ Gender:________SSN#__________________ DOB:________________

Student: Y/N Married: Y/N Veteran: Y/N Email Address________________________________

Mailing Address: __________________________City:____________State:________Zip:_______

PO Box (if applicable):______________________City:____________State:________Zip:_______

Home Phone: ________________________________Cell Phone: ____________________________

Primary Employer: _____________________________Work Number: _________________________

Emergency Contact: _______________________ Relationship:__________Phone:________________

Primary Care Physician:___________________________How did you hear about us?_____________

Primary Insurance:_____________________________ Policy Number:_________________________

Policy Holder Name:__________________________________ DOB:____________________

Secondary Insurance Name: __________________________ Policy Number:___________________

Policy Holder Name:__________________________________ DOB:_____________________

Was your injury due to: Motor Vehicle Accident Y/N Work Related Accident Y/N

Other, please specify:____

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CAPE COD ORTHOPAEDICS & SPORTS MEDICINE P.C.
130 North Street, Hyannis, MA 02601 **Today's Date**____________

STATEMENT OF FINANCIAL RESPONSIBILITY ***(Must be 18 years of age to Sign)***
I authorize Cape Cod Orthopaedics & Sports Medicine P.C. to release any information required in the course of this examination and my treatment to my insurance company, primary care physician or other third party as requested by me. I also authorize and direct payment of all medical/surgical benefits directly to Cape Cod Orthopaedics & Sports Medicine, P.C. I understand my Insurance and/or Medicare may not cover all charges and agree to accept responsibility for payment of those charges. If for any reason my account becomes delinquent, I agree to pay all interest, rebilling charges, collection costs and reasonable legal fees. I understand there is a $25.00 No Show/Cancellation fee if I fail to cancel any office appointment within 24 hours of the scheduled visit, and a $250.00 Cancellation fee if I fail to cancel any scheduled surgery within 7 days of the date of surgery. A copy of our No Show/Cancellation policy is available upon your request.

Signature of Patient or Guardian ______________________________ **Date** ____________________

STATEMENT TO AUTHORIZE PAYMENT OF MEDICARE BENEFITS ***(Medicare Patients Only)***
I request payment of authorized Medicare benefits be paid on my behalf to Cape Cod Orthopaedics and Sports Medicine, P.C. for any services furnished by their physicians and providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits, or the benefit payable for related services.

Signature of Patient ______________________________ **Date**__________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT PATIENT CONSENT FORM

I understand that, under the Health Insurance and Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosures of my health information. I understand that Cape Cod Orthopaedics & Sports Medicine, P.C. has the right to change its "Notice of Privacy Practices" from time to time and that I may contact Cape Cod Orthopaedics & Sports Medicine, P.C. at any time at the address above to obtain a current copy of the "Notice of Private Practices".

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time except to the extent that you have taken action relying on this consent.

I also authorize this practice to disclose my medical information

Primary Care Physician:	Yes ________	No ________
On my answering machine/voicemail:	Yes ________	No ________
To my spouse:	Yes ________	No ________
To my adult children:	Yes ________	No ________

To the following additional family and or friend(s) name: ______________________

______________________________ ____________________
Signature of Patient/Guardian/Personal Representative Date

Patient Name ______________________________ Date of Birth____________________

Patient Name ____________

Date of Birth ____________

HISTORY OF PRESENT ILLNESS (PLEASE PRINT) Today's Date ____________

Body part(s) to be evaluated: ____________

Was your injury due to a: ○ Motor vehicle accident ○ Work related injury ○ Liability ○ Other

If yes, Date of injury ____________

Where and how did your injury occur? ____________

Have you been treated by a physician for **THIS** problem? ○ No ○ Yes Dr. Name ____________

Was an MRI and /or X-Ray taken for **THIS** problem? ○ No ○ Yes If Yes, Where ________ When ______

What treatments have you had to date for **THIS** problem: ○ Physical Therapy ○ Splints ○ Medication

○ Surgery ○ Exercise ○ Injection ○ Chiropractor ○ Podiatrist

SOCIAL HISTORY

Occupation ____________ Education ____________

Do You? **Smoke** ○ Never ○ Yes ○Former **Alcohol** ○ No ○ Yes **Caffeine** ○ No ○ Yes Height ____ Weight ____

Recreational drugs ○ No ○ Yes ○ Lt handed ○ Rt handed **Activity level:** ○ Above ○ Average ○ Sedentary

Exercise Frequency ____________ Type of Exercise ____________

CURRENT MEDICATIONS (PLEASE PRINT)	REASON

Medication Allergies: ____________

Other Allergies: ____________

Preferred Pharmacy: ____________

Name Town/Address Phone #

SURGERIES (Side if Applicable) and YEAR:

________(____) ________(____) ________(____) ________(____)

Patient Name ______________________

Date of Birth ______________________

PAST MEDICAL HISTORY & ILLNESS (PLEASE CHECK) **Today's Date** ______________________

o Alcoholism	o Alzheimer's	o Anemia	o Arthritis	o Asthma	o Blood Clots
o Cancer (TYPE)	o Depression	o Diabetes	o Drug Abuse	o High Cholesterol	o Hypertension (HighBP)
o Gout	o Heart Disease	o Hepatitis	o Kidney Disease	o Osteoarthritis	o Seizures
o Ulcers	o	o	o	o	o

FAMILY MEDICAL HISTORY (PLEASE CHECK)

DISEASE:	FAMILY MEMBER(S)
o CANCER (TYPE) ______________	o Mother o Father o Sister o Brother o Grandmother Maternal/Paternal o Grandfather Maternal/Paternal
o DIABETES	o Mother o Father o Sister o Brother o Grandmother Maternal/Paternal o Grandfatherr Maternal/Paternal
o HEART DISEASE	o Mother o Father o Sister o Brother o Grandmother Maternal/Paternal o Grandfather Maternal/Paternal
o HYPERTENSION (HIGH BLOOD PRESSURE)	o Mother o Father o Sister o Brother o Grandmother Maternal/Paternal o Grandfather Maternal/Paternal
o OSTEOPOROSIS	o Mother o Father o Sister o Brother o Grandmother Maternal/Paternal o Grandfather Maternal/Paternal
o OSTEOARTHRITIS	o Mother o Father o Sister o Brother o Grandmother Maternal/Paternal o Grandfather Maternal/Paternal
o OTHER ______________	o Mother o Father o Sister o Brother o Grandmother Maternal/Paternal o Grandfatherr Maternal/Paternal

REVIEW OF SYSTEMS

Please mark if you have any of these symptoms TODAY:

CONSTITUTIONAL:
o Fever o Fatigue o Night Sweats

HEENT:
o Vision o Headaches

CARDIOVASCULAR:
o Chest Pain o Palpitations

RESPIRATORY:
o Cough o Shortness of Breath

GASTROINTESTINAL:
o Vomiting o Diarrhea o Constipation

GENITOURINARY:
o Urinary Difficulty o Pain o Blood

SKIN:
o Rashes o Changes Skin o Changes Hair

NEUROLOGICAL/PSYCHIATRIC:
o Dizziness o Emotional Disturbances

METABOLIC/ENDOCRINE:
o Cold Intolerance o Heat Intolerance