TYGART VALLEY ORTHOPEDICS AND SPORTS MEDICINE
CONSENT FOR TREATMENT

Patient Name:______________________________________ **Date:**_______________________

Consent for Treatment

1. **CONSENT FOR TREATMENT:** I certify that I am the patient/parent/guardian or person legally responsible for the patient named above. I hereby authorize and consent to treatment for the patient by all medical care providers working for or under Tygart Valley Orthopedics & Sports Medicine.
2. **NOTICE OF DEEMED CONSENT FOR HIV BLOOD TESTING:** In the event that a heath care worker is exposed to blood or other potentially infectious body fluids, I hereby authorize testing for hepatitis and HIV-the virus that causes AIDS with release of results to the exposed person.
3. **RELEASE OF MEDICAL INFORMATION OR RELATED DATA:** I hereby authorized Tygart Valley Orthopedics & Sports Medicine to release or request from/to any physician, his/her office, or any other medical provider or facility any information necessary for referral, payment, reimbursement or collection purposes.
4. **LIFETIME SIGNATURE AUTHORIZATION FOR MEDICARE PATIENTS AND RELEASE AUTHORIZATION FOR PRIVATE INSURANCE:** I request and direct the patient of authorized Medicare and/or other third party payments and insurance benefits to be made on my behalf Tygart Valley Orthopedics & Sports Medicine for services rendered. I authorize the holder of medical information about me to be release to the Health Care Financing Administration, other insurance companies, and/or other third party payors and their agents and information companies, and/or other third party payors and their agents any information needed to determine these benefits payable for related services.

I certify that I am the patient/parent/guardian or person legally responsible for the above patient. In consideration of the services rendered to me, I have read, understand , and agree to the above for (4) statements,

_____________________________ _____________________________ _______________

Print Patients Name | Patients or Authorized Representative Signature | Date

NOTICE OF PRIVATE PRACTICES

Signature below is acknowledgement that you have received Tygart Valley Orthopedics and Sports Medicine's Notice of Private Practices.

_____________________________ _____________________________ _______________

Print Name | Signature | Date

Patient Authorization for Release of Health Information

I, ____________________________(name of patient or patient's representative), hereby authorize permission for the following person(s) to discuss, call, or pick up medical information on my behalf.

_____________________________ _____________________________

Name of Authorized Contact | Phone No.

_____________________________ _____________________________

Name of Authorized Contact | Phone No.

_____________________________ _____________________________ _______________

Print Name | Signature | Date

Tygart Valley Orthopedics and Sports Medicine

PATIENT INFORMATION Today's Date ____________________

Name of Patient: __________________________ Age: ______ DOB: ______________________

Address: _________________________ City: ____________________ State: _____ Zip: ______

Home Phone: _______________ Cell Phone: _____________ SSN: ___________________ Sex: ___

Occupation: _______________________ Employer: _____________________ Phone: __________

Email Address: ____

RESPONSIBLE PARTY INFORMATION □ **Same As Patient**

Name: ________________________________ DOB: _________ Sex: ___ SSN: _____________

Address: _________________________ City: ____________________ State: _____ Zip: ______

Relationship to patient: ____

Employer: _________________________ Work Phone: _________ Home: ________ Cell: ________

SPOUSE OR PARENT INFORMATION

Name: ____ DOB: ______________________

IF A CHILD: Mother's Name: _____________________________________ DOB: ______________

IF A CHILD: Father's Name: ______________________________________ DOB: ______________

ADDITIONAL INFORMATION

Name of nearest relative not living with you: ___________________________ Phone: ____________

Who referred you to our office? ____

IN MY ABSENCE, I GIVE PERMISSION TO TYGART VALLEY ORTHOPEDICS TO RELEASE MY TEST RESULTS OR DISCUSS MY CARE WITH FAMILY MEMBER:

(Name) ____

Signature of Patient ____

INSURANCE INFORMATION

Primary Ins. ____________________________
Group # ____________ ID# ______________
Ins Phone # ____________________________
Policy Holder ___________________________

2nd Ins. ____________________________
Group # ______________ ID# ______________
Ins Phone # ____________________________
Policy Holder ___________________________

I hereby authorize Tygart Valley Orthopedics to furnish my designated insurance carrier any information concerning previous illness or injury. I also authorize under this claim to be made payable directly to Tygart Valley Orthopedics. I understand I am responsible financially to the physician for charges not covered by this authorization.

SIGNATURE: ____ **DATE:** ________________

TYGART VALLEY ORTHOPEDICS AND SPORTS MEDICINE

Patient Name:______________________________ **Date:**__________________

Reason For Visit:______________________________ Date Of Onset:__________________

Is this a Work or Auto-Related Injury? YES / NO If yes, is Litigation Ongoing? YES / NO

Family Physician:______________________________ Date Of Last Physical:__________________

Pharmacy, City:______________________________ Height:____________ Weight:____________

Smoking or Chewing Tobacco: YES /NO How much:____________ Years of use:__________________

Alcohol: YES /NO How much:____________ Years of use:__________________

Caffeine Intake: YES / NO How much:____________

Special Diet: YES / NO If yes, what type:____________________

Advance Directives: Do you have a Living Will or Medical Power of Attorney? YES / NO

Deaf or Difficulty Hearing: YES / NO
Difficulty Concentrating or Memory Problems: YES / NO
Difficulty Dressing or Bathing: YES / NO
Blind or Difficulty Seeing: YES / NO
Difficulty Walking or Climbing Stairs: YES / NO
Difficulty Doing Errands Alone: YES / NO

Please List any drug allergies and specific reactions:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Are you Allergic to Latex: YES / NO

Surgical History: ***(please include date, type of surgery, and doctor)***

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Family History: (please include relationship and condition)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

PATIENTS MEDICATION LIST

Please list all medication you are currently taking, please place on the back of sheet if more room is required:

NAME **DOSE** **FREQUENCY**

____
____
____
____
____
____

PLEASE LIST ANY/ALL
PAST MEDICAL HISTORY

History of bleeding: blood clots, pulmonary embolis? Y / N________________

Stents, metal implants? Y / N________________

Any vaccine reactions, bee sting, frequent infections? Y / N________________

Any bruising, anemia, easy bleeding, low blood count, swollen/tender lymph nodes? Y / N________________

Have you ever had a bone density test, if so when? Y / N________________

Have you had cancer of any kind? Y / N________________

Any heart attack, irregular heartbeat, chest pain? Y / N________________

Do you have Coronary Artery Disease? Y / N________________

Any dental problems with teeth or gums? Y / N________________

Any hearing loss, ringing in ears, Frequent cough sore throat? Y / N________________

Problem such as diabetes or thyroid problems? Y / N________________

Any glasses, contacts, glaucoma, eye disease? Y / N________________

Fevers, chills, unplanned weight loss? Y / N________________

Any heartburn, ulcers, bleeding, hiatal hernia, chronic diarrhea, constipation? Y / N________________

Difficulty urinating, burning, itching, discharge, kidney stones, bladder problems? Y / N________________

Have you ever had or been exposed to HIV, AIDS, Tuberculosis (TB), hepatitis, yellow jaundice? Y / N________________

Any hepatitis or yellow jaundice (problems with liver)? Y / N________________

Asthma, emphysema, chronic cough, wheezing, Shortness of breath? Y / N________________

Have you had Methicillin Resistant Staph Aureus? Y / N________________

Any neck or back pain, gout, fractures? Y / N________________

Any stroke, Parkinson's, dizziness, tremor, seizures, fainting, numbness, or weakness? Y / N________________

Any depression, anxiety, tension, nervousness, panic attacks? Y / N________________

Any rashes, lumps psoriasis, eczema? Y / N________________

Have you had Vancomycin Resistant Enterococcus? Y / N________________

Any high/low blood pressure, phlebitis, aneurysm, blood clots? Y / N________________

ONLY PRESENT MEDICAL SYMPTOMS

(*please circle* any of the following)

CONSTITUTIONAL
Fever
Night Sweats
Weight Gain (_____lbs)
Weight Loss (_____lbs)
Exercise Intolerance

EYES
Dry Eyes
Irritation
Vision Changes

ENMT
Ear: Difficulty Hearing
Ear Pain
Nose: Frequent Nose Bleeds
Nose or Sinus Problems
Mouth/Throat: Sore Throat
Bleeding Gums
Snoring
Dry Mouth
Mouth Ulcers
Oral Abnormalities
Teeth Problems

CARDIOVASCULAR
Chest Pain
Arm Pain on Exertion
Shortness of Breath When Walking
Shortness of Breath When Lying Down
Palpitations
Known Light Headedness on Standing

RESPIRATORY
Cough
Wheezing
Shortness of Breath
Coughing up Blood
Sleep Apnea

GASTROINTESTINAL
Abdominal Pain
Vomiting
Abnormal Appetite
Change in Appetite
Black or Tarry Stools
Frequent Diarrhea
Vomiting Blood

GENITOURINARY
Urinary Loss of Control
Difficulty Urinating
Hematuria
Increased Urinary Frequency
Incomplete Emptying

MUSCULOSKELETAL
Muscle Aches
Muscle Weakness
Arthralgias/Joint Pain
Back Pain
Swelling in the Extremities

INTEGUMENTARY
Abnormal Mole Jaundice
Rash
Itching or Dry Skin
Growths or Lesions

NEUROLOGIC
Loss of Consciousness
Weakness
Numbness
Seizures
Dizziness
Frequent or Severe Headaches
Migraines
Restless Legs

PSYCHIATRIC
Depression
Sleep Disturbances
Feeling Safe in Relationship
Alcohol Abuse
Restless Sleep

ENDOCRINE
Fatigue
Increased Thirst
Hair Loss
Increased Hair Growth
Cold Tolerance

HEMOTOLOGIC/LYMPHATIC
Swollen Glands
Easy Bruising
Excessive Bleeding

ALLERGIC/IMMUNOLOGIC
Runny Nose
Sinus Pressure
Itching
Hives
Frequent Sneezing