



Date: _____

Patient Name: _____ **Date of Birth:** _____

Address: _____
Street City State Zip

Cell Phone: _____ **Home Phone:** _____ **Work Phone:** _____

Email: _____ **Sex:** M F **Race/Ethnicity:** _____

Height: ____ **Weight:** ____ **Occupation:** _____ **Employer's Name:** _____

Emergency Contact Name: _____ **Tel:** _____ **Relationship to Patient:** _____

Primary Care Physician: _____ **Phone:** _____ **Fax:** _____

Preferred Pharmacy (Name, Address, Phone): _____

Primary Insurance

Name: _____ **Phone:** _____ **Group #:** _____ **ID #:** _____

Subscriber Name (If not patient): _____ **Subscriber DOB:** _____ **Effective Date:** _____

Secondary Insurance

Name: _____ **Phone:** _____ **Group #:** _____ **ID #:** _____

Subscriber Name (If not patient): _____ **Subscriber DOB:** _____ **Effective Date:** _____

Chief Complaint

Side: Left Right Both **Body Part:** Shoulder Knee Hip **Other:** _____

Duration of symptoms: _____ **Pain rating (0-10):** _____

Briefly describe origin of current problem and current symptoms: _____

What makes your symptoms worse: _____

Recent Trauma history to the affected area? Yes No **If yes, Injury date:** _____

Prior Injuries to the affected area? Yes No **If yes, Prior Injury date:** _____

Description (If yes to above 2 questions): _____

Important Sports/Recreational Activities/Hobbies: _____

Additional information: _____

Treatment: None If yes to prior treatment, list details below.

- Activity Modification: _____
- NSAIDS (e.g Ibuprofen, Naproxen. List dose/frequency): _____
- Oral Medications (Tylenol, Other Meds. Dose/frequency): _____
- Physical Therapy (Name/Location/# sessions attended): _____
- Home Exercise Program (Exercises/frequency): _____
- Injections (Steroid, Gel, PRP. Date/Type of Injection/Outcome): _____
- Imaging (X Rays, MRI, CT, Nerve Conduction. Date/Imaging center name): _____
- Prior Surgery (Date/Procedure/Surgeon/Outcome): _____
- ER Visit (Date/Hospital name/Treatment): _____
- Urgent Care Visit (Date/Facility name/Treatment): _____
- Splinting/Bracing (Date/Duration of use): _____
- Treatment by Another Physician (Date/Name/Treatment): _____
- Assistive Devices (Cane, Scooter, Walker. Frequency): _____
- Other/Additional Information: _____

Past Medical History: None

- | | | |
|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GI ulcers | <input type="checkbox"/> Narcotic use (active) |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Gout | <input type="checkbox"/> NIDDM |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> PVOD |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Renal disease |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Drug/Alcohol abuse | <input type="checkbox"/> IDDM | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> DVT (Blood clots)/PE | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Steroid use |
| <input type="checkbox"/> Emphysema/Bronchitis | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Narcotic use (in the past) | |

Past Surgical History: None Please list the date of surgery next to the procedure.

- | | | |
|---|---|--|
| <input type="checkbox"/> Cervical spine surgery | <input type="checkbox"/> Knee arthroscopy (Left) | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Lumbar spine surgery | <input type="checkbox"/> Knee arthroscopy (Right) | <input type="checkbox"/> Partial colectomy |
| <input type="checkbox"/> Shoulder arthroscopy (Left) | <input type="checkbox"/> TKA (Left) | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Shoulder arthroscopy (Right) | <input type="checkbox"/> TKA (Right) | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> THA (Left) | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Wisdom teeth extraction |
| <input type="checkbox"/> THA (Right) | <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Other: _____ |

Family History (Family members with a history of blood clots (DVT), pulmonary embolism (PE), cancer, heart attack, stroke, autoimmune disease, or other serious medical condition): None

Social History:

Smoke/Use tobacco: Yes No If yes, packs/day: _____ Number of years smoking: _____

Drink alcohol: Yes No If yes, how much/how often: _____

Street drugs: Yes No If yes, which drugs, how much, and how often: _____

Allergies: None Penicillin Latex Other: _____

Medications (Name, dose, frequency): None _____

Review of Systems: Negative for all items listed below

Constitutional: Weight loss Loss of appetite Fatigue

Eyes: Blurred vision Double Vision

Cardiovascular: Chest pain Irregular heartbeat

Respiratory: Chronic cough Shortness of breath

Gastrointestinal: Nausea Vomiting Blood in stool Abdominal pain Diarrhea

Genitourinary: Blood in urine Difficulty urinating Recurrent bladder infections

Kidney problems

Skin: Rashes Chronic skin ulcers/wounds

Neurological: Headaches Dizziness Seizures

Psychiatric: Persistent difficulty sleeping Feelings of hopelessness Excessive sadness

Endocrine: Unintentional weight loss Rapid weight gain

Hematologic/Lymphatic: Easy bleeding Excessive bruising Chronic arm or leg swelling

Worker's Compensation (If applicable): Company Name: _____

Adjuster: _____ Adjuster Phone: _____ Adjuster email: _____

Claim #: _____ Date of Injury: _____

Dr. John Austin has the ability to send your statements through McGavran Billing (our billing partner) electronically at mcgavranbilling@gmail.com. If you would like to receive your statements via email please check the box below and provide your email address.

Yes, I would like to receive statements at the following email address: _____

No, I would like to receive a paper statement. Send paper statement to my home address unless I indicate a different address here: _____

Northwest Orthopaedic Surgery
8929 University Center Lane, Suite 205
San Diego, CA 92122

Text/Voice 858.703.6964
info@nworthosurgery.com

Consent for Evaluation and Treatment

I consent to the evaluation and treatment of the condition for which I (or my child/dependent) have come to Northwest Orthopaedic Surgery. I authorize the physicians (and other health care providers and staff associated with Northwest Orthopaedic Surgery) to provide such evaluation and treatment. I understand that medical staff and medical providers in training may be involved in my care and treatment, and I consent to their involvement. I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, diagnosis, treatment, or test performed at or by Northwest Orthopaedic Surgery. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at Northwest Orthopaedic Surgery.

I Agree to the above Consent for Evaluation and Treatment

Consent for Procedures

Certain orthopaedic conditions may require additional testing and/or procedures as part of the treatment plan. The tests and/or procedures are separate from the physician's office visit and thus have a separate charge. These tests and/or procedures include, but are not limited to:

- Steroid Injection
- Hyaluronic Acid Injection
- Biologic Injection
- Local Anesthetic Injection
- Casting/Splinting
- Fracture Treatment (including Manipulation)
- Durable Medical Equipment
- Minor Surgical Procedures and/or biopsies

I Agree to the above Consent for Procedures

I have had the opportunity to discuss this consent, and my questions have been answered to my complete satisfaction.

Signature of Responsible Party: _____ Date: _____