LEMAK HEALTH

Today's Date: _____ **Email:** _____

Name: _____
(Last) (First) (MI) (Nick Name)

Marital Status: _____ **Sex: M F Date of Birth:** __/__/___ **SS#** __/__/____

Address: _____
Street Number or P.O. Box City State Zip

Home Phone: (**) ___- _____ Work: (** **) ___- ____ Cell: (** **) ___- _____**

Emergency Contact: _____ **(** **) ___-____**
Name and Relationship of person outside Immediate Home Phone Number

Name of Spouse: _____ **Spouse Employer:** _____

Patient's Employer: _____

School: _____ **Sport:** _____

How did you hear about us? _____

Reason for visit? _____

Date of Injury/Accident Occurred: ___ /___ /_____

How did injury occur: _____

Drug Allergies: _____

Primary Insurance: _____ **Secondary Insurance:** _____

Policy Holders Name: _____ Policy Holders Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

DOB:__/__/____ SS# ___/__/_____ DOB:__/__/____ SS#:___/__/_____

Contract # _____ Grp#_____ Contract # _____ Grp#_____

Policy Holders Employer: _____ Policy Holders Employer: _____

Is this a WORKMAN COMPENSATION CASE? Yes _ No _
If yes, please provide the following:

Date Of Injury: ___/___/_____ Employer: _____

Work Comp Carrier: _____ Address: _____

List any Coach, Trainer, or Doctor and Complete Address that you want to receive a report.

Doctor: _____

Coach/Trainer: _____

Pharmacy: _____ **Phone: (** **) ___-_____**

Address: _____

New Patient History & Intake Form

Patient Information

Patient Name: _____ Date of Birth: ___/___/_____

Date of Visit (Today's Date): ____/____/_____ Date of Injury (if applicable): ____/____/_____

Right or Left Handed: _____ Referring Provider: _____

Preferred Pharmacy Name/Address: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Past Medical History (Please check all that apply):

- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Irregular Heartbeat
- ☐ Bipolar Disorder
- ☐ Breast Cancer
- ☐ Hyperlipidemia
- ☐ Ischemic Heart Disease
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non Insulin
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity, Morbid
- ☐ Obesity
- ☐ PBPH
- ☐ Prostate Cancer
- ☐ Pulmonary Embolism
- ☐ Radiation Therapy
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke
- ☐ **NONE**
- ☐ Other _____

Past Surgical History (Please check all that apply):

- ☐ Appendix (Appendectomy)
- ☐ Breast: Mastectomy ORight OLeft OBoth
- ☐ Breast: Lumpectomy ORight OLeft OBoth
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Gallbladder Removal
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Removed: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Hysterectomy
- ☐ Hysterectomy: Caesarean
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ **NONE**
- ☐ Other _____

_____

Past Orthopedic History (Please check all that apply):

- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Bursitis
- ☐ DISH
- ☐ Epidural Injections, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP,Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ **NONE**
- ☐ Other _____

Past Orthopedic Surgery (Please check all that apply):

- ☐ Achilles Tendon Repair
  - O Right O Left O Both
- ☐ ACL Reconstruction
  - O Right O Left O Both
- ☐ Ankle Fracture ORIF
  - O Right O Left O Both
- ☐ Bunion Correction
  - O Right O Left O Both
- ☐ Carpal Tunnel Decompression
  - O Right O Left O Both
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ Distal Radius ORIF
  - O Right O Left O Both
- ☐ Ganglion Cyst Excision
- ☐ Intermedullary Nailing Femur
  - O Right O Left O Both
- ☐ Intermedullary Nailing Tibia
  - O Right O Left O Both
- ☐ Joint Replacement: **Hip**
  - O Right O Left O Both
- ☐ Joint Replacement: **Knee**
  - O Right O Left O Both
- ☐ Joint Replacement: **Shoulder**
  - O Right O Left O Both
- ☐ Knee Arthroscopy
  - O Right O Left O Both
- ☐ KyphoplastyNertebroplasty
- ☐ Lumbar Fusion
- ☐ Lumbar Laminectomy
- ☐ Lumbar Spine Surgery: Decompression
- ☐ Lumbar Spine Surgery: Decompression & Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement
- ☐ Meniscus Repair
  - O Right O Left O Both
- ☐ Reverse Total Shoulder Replacement
  - O Right O Left O Both
- ☐ Revision of Total **Knee** Arthroplasty
  - O Right O Left O Both
- ☐ Revision of Total **Shoulder** Arthroplasty
- ☐ O Right O Left O Both
- ☐ Rotator Cuff Repair
  - O Right O Left O Both
- ☐ Shoulder Arthroscopy
- ☐ O Right O Left O Both
- ☐ Trigger Finger Release
  Location: _____
- ☐ **NONE**
- ☐ Other: _____

Social History (Please check all that apply):

Cigarette Smoking

- ☐ Never Smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily
  - # packs per day____

Alcohol Use

- ☐ Do not drink alcohol
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Exercise Frequency

- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never

Medications (Please list all current medications or check option which applies):

- ☐ I brought a copy of my medication list *(Please provide the list to the front desk receptionist)*
- ☐ Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

Allergies (Please list all known allergies or check option which applies):

- ☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)
- ☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

Family History (Please inform us of your family members' medical history by marking the appropriate box):

	Mother	Father	Sister	Brother	Daughter	Son	Other:
Hypertension							
Osteoarthritis							
Osteoporosis							
Scoliosis							
Diabetes, Type 2							
Other _____							

- ☐ **No Family History** (Checking this box indicates no past family medical history)

Review of Systems* (Check **YES** or **NO** if you are currently experiencing any of the following):

Symptom	YES	NO
Joint pains		
Joint swelling		
Joint stiffness		
Unsteady gait		
Numbness		
Tingling		
Unexpected weight loss		
Fever		
Chills		
Poor healing wounds		
Scarring/Keloids		
Easy bleeding		

Alerts* (Check **YES** or **NO** for the following):

Alert	YES	NO
Pacemaker		
Blood thinners		
Defibrillator		
Premedication prior to procedures		
Rheumatoid Arthritis		
RSD		
Allergy to shellfish/iodine		
Allergy to latex		
Allergy to adhesive		
Under pain management		

*Please inform the physician, medical assistant or front desk staff of any other medical conditions or concerns.

LEMAK HEALTH

Authorization for Medical Treatment: The undersigned will be informed of the treatment procedures considered necessary for the patient and that the treatment/procedures will be directed by a physician and performed by employees of Lemak Health. The undersigned understands that no guarantee for assurance has been made as to the results that may be obtained from treatment. Authorization is hereby granted for treatment.

Information Privacy: Lemak Health will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website, and have copies available for distribution. The undersigned acknowledges receipt of this information.

Release of Information: Lemak Health is hereby authorized to disclose all or part of my information regarding medical condition, treatment and prognosis to insurance carriers, other treating physicians, trainers, rehabilitation nurses, orthopedic technicians and/or coaches. I also authorize Lemak Health to utilize medical information obtained during the course of my treatment in medical research and education programs, provided my name and likeness are not revealed and my privacy is completely protected.

Assignment of Insurance Benefits: In the event the undersigned is entitled to benefits of any kind whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to Lemak Health for application on the patient's bill. The undersigned and/or patient agrees to be responsible for charges not covered by the assignment, including deductibles and co-payments prescribed by law.

Financial Agreement: The undersigned agrees that in consideration for the services to be rendered to the patient, he/she individually agrees to be totally responsible for all charges for services, including any non-covered charges. The undersigned agrees to assign payment for the unpaid charges from services provided by a specialist and by physicians for whom Lemak Health is authorized to bill. Should the account be referred to an attorney for collection, the undersigned agrees to pay all costs of collections, including reasonable attorney fees of one third of the balance. All delinquent balances shall bear interest at the legal rate.

Medicare Authorization: I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible in part for my treatment. (Section 11288 of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

Miscellaneous Provisions: I understand that under no circumstances will Lemak Sports Medicine be liable for property of patients.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, IS THE PATIENT OR ONE AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE, AND ACCEPTS THE TERMS THEREOF.

Undersigned (Patient's Signature)

Signature - If signed by Undersigned's Authorized Agent

Witness

Relationship to Undersigned

Witness - Need Only if Signatures are Made By Mark (X)

Month Day Year Time (AM/PM)

Date and Time of Signing

LEMAK HEALTH

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH:_____ **SSN:** _____

PATIENT ADDRESS: _____

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization. Subject to certain exceptions, you have the right to inspect and copy the protected health information.

I give any physician, staff, employee, or representative of Lemak Health, Inc. permission to discuss my account and medical information which may include symptoms, treatments, diagnosis, test results, medications, appointment dates and times, or any other type of protected health information with the following person(s):

None_____

Spouse_____ Parent _____

Guardian _____ Adult Child _____

Friend _____ Other _____

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognized that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

_____ _____

Patient Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am:

_____

LEMAK HEALTH

Patient Name: _____

How did you hear about us?

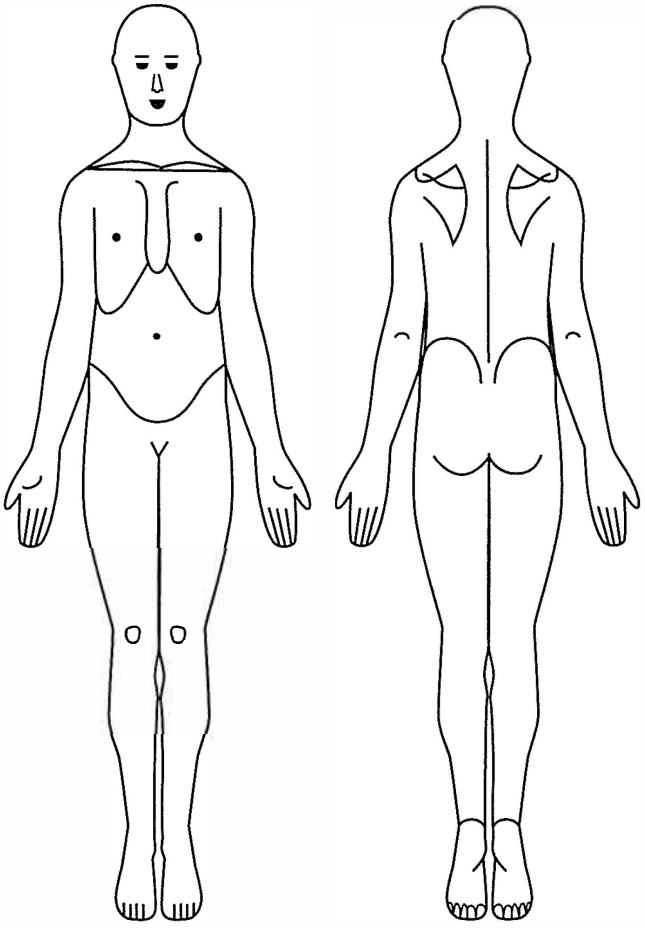
Please select one of the following:

- Internet
  - Google Search
  - Online Advertising
  - Facebook
  - Email
  - Website
  - Other: _____
- Billboard
- Gym
- Radio Station
- Newspaper/Magazine
- Television
- Friend or Family:_____
- Primary Care Physician:_____
- Other physician: _____
- Emergency Room
- Urgent Care
- Employer
- Insurance Company
- Yellow Pages
- Health Fair Event
- Community Event
- Attorney
- Athletic Trainer
- Coach
- Former Patient
- Referring Provider
- School: _____
- Self (You've known Lemak for years)

LEMAK HEALTH

Patient Name: Date:

PLEASE CIRCLE WHAT BODY PARTS YOU HAVE ISSUES WITH



MIPS

Todays Date: _____
Patient Name: _____
DOB: _____

*Quality

Has any of your medications changed from your last visit? Yes No

If yes, please list:
_____
_____

Height _____ Weight _____

Have you ever smoked tobacco? Yes No

Do you currently smoke tobacco? Yes No

Do you drink alcohol? Yes No

If so, do you drink more than 2 on a daily basis? Yes No

Have you received the Flu Vaccination this year? Yes No

Have you received the Pneumonia Vaccination this year? Yes No