Sports Medicine North
ORTHOPAEDIC SURGERY, INC

OFFICE USE ONLY
❒ ID Checked Patient Acct # _____
Scheduled Appt MD: _____

COMPLETE ENTIRE SECTION (PLEASE PRINT)

NAME			**DATE OF BIRTH**	**AGE**	
STREET			**EMPLOYER**		
CITY	**STATE**	**ZIP CODE**	**STREET**		
PHONE (Primary)	❒ Cell ❒ Home		**CITY**	**STATE**	**ZIP CODE**
PHONE	❒ Cell ❒ Home ❒ Work		**EMPLOYER PHONE #**		
SOCIAL SECURITY #			**EMAIL ADDRESS (Optional)**		
OCCUPATION			**EMERGENCY CONTACT (Name/Tel#)**		
MARITAL STATUS	**GENDER**		**PREFERRED LANGUAGE**		

RACE: ❒ Decline to Answer
❒ American Indian/Alaska Native ❒ Asian
❒ Black/African American ❒ White
❒ Native Hawaiian/Pacific Islander ❒ Other

ETHNICITY:
❒ Hispanic ❒ Non-Hispanic ❒ Other ❒ Decline to Answer

HOW DID YOU HEAR ABOUT SMN? (PCP, Friend, Therapist, Google, etc.)

PHARMACY NAME		**STREET**
CITY	**STATE**	**TELEPHONE #:**

PRIMARY CARE & CONSULTING DOCTOR INFORMATION

PRIMARY CARE PHYSICIAN (PCP)	**TELEPHONE #:**
PCP ADDRESS	
PHYSICIAN REQUESTING CONSULT [If requesting physician is PCP, check this box ☐]	**TELEPHONE #:**
PHYSICIAN ADDRESS	

BILLING INFORMATION

PRIMARY INSURANCE NAME	**CERTIFICATE #**	**SUBSCRIBER**	**SUBSCRIBER DOB**
SECONDARY INSURANCE NAME	**CERTIFICATE #**	**SUBSCRIBER**	**SUBSCRIBER DOB**
GUARANTOR			

WERE YOU INJURED AT WORK

❒ Yes → ***IF YES, PLEASE FILL OUT WORKER'S COMPENSATION INSURANCE FORM*** ❒ No

IS THIS INJURY RELATED TO AN AUTOMOBILE ACCIDENT

❒ Yes → ***IF YES, PLEASE FILL OUT MOTOR VEHICLE ACCIDENT FORM*** ❒ No

Sports Medicine North Financial Policy

Your insurance policy is a contract between you and your insurance company. As a courtesy, Sports Medicine North will file your insurance claim with your insurance company. Patients are responsible for any copayments and deductibles. If for any reason, including referral issues, your insurance company does not pay, you are ultimately responsible for payment of all charges associated with your visit. It is a patient's responsibility to obtain any necessary referrals and to check with their insurance company to make sure the doctor they are seeing is on their insurance plan or in network if necessary. I have read and understand Sports Medicine North's financial policy and I agree to the terms. I authorize the release of any medical information necessary to process this claim and authorize payment to Sports Medicine North. Photocopy of this authorization is permitted.

I have read and understand Sports Medicine North's financial policy and I agree to the terms. I authorize the release of any medical information necessary to process this claim and authorize payment to Sports Medicine North. Photocopy of this authorization is permitted.

DATE _____ **SIGNATURE (PATIENT OR AUTHORIZED PERSON)** _____

Patient Name _____ **Patient ID:** _____ **Date:** _____

MEDICAL HISTORY (please circle Yes or No):					
Heart Attack	**Yes No**	Kidney Disease	**Yes No**	Post-Menopausal	**Yes No**
High Blood Pressure	**Yes No**	Hepatitis	**Yes No**	AIDS/HIV+	**Yes No**
Heart Disease/Angina	**Yes No**	Thyroid Disease	**Yes No**	Arthritis	**Yes No**
Heart Failure	**Yes No**	Diabetes	**Yes No**	Osteoporosis	**Yes No**
High Cholesterol	**Yes No**	RA/Lupus	**Yes No**	Prior Fractures	**Yes No**
Mitral Valve Prolapse	**Yes No**	Gout	**Yes No**	Depression/Anxiety	**Yes No**
Anemia	**Yes No**	COPD	**Yes No**	Glaucoma	**Yes No**
Clotting Problems	**Yes No**	Tuberculosis	**Yes No**	Chronic Infection	**Yes No**
DVT	**Yes No**	Asthma	**Yes No**	Hip Fracture	**Yes No**
Pulmonary Emboli	**Yes No**	Stomach Ulcer	**Yes No**	Other:	
Stroke/TIA	**Yes No**	Cancer	**Yes No**		
Have you ever been diagnosed with MRSA?			**Yes No**		

Please answer all of these questions as accurately as possible. If you do not understand the questions, please ask for assistance.

SURGICAL HISTORY (please check if applicable)

☐ Internal Cardiac Defibrillator
☐ Pacemaker
☐ Coronary Bypass
☐ C-Section
☐ Appendectomy
☐ Gall Bladder
☐ Hysterectomy

☐ Joint Replacement
If yes, please explain: _____
☐ Gastric Bypass
If yes, please explain: _____
☐ Spinal Surgery
If yes, please explain: _____

Surgical History Other (please add any surgical history not listed above):

ALLERGIES TO MEDICATIONS: (Iodine, Latex, Dye)

MEDICATION LIST (please list all medication you are currently taking or attach a sheet):

FAMILY HISTORY					
Cancer	**Yes No**	Depression/Anxiety	**Yes No**	Diabetes	**Yes No**
Bleeding Problems	**Yes No**	Clotting Problems	**Yes No**	Anesthesia Problems	**Yes No**
Heart Disease	**Yes No**	Hip Fracture	**Yes No**	Osteoporosis	**Yes No**

Patient Name _____ **Patient ID:** _____ **Date:** _____

SOCIAL HISTORY:

ARE YOU? ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

WHOM DO YOU LIVE WITH?

CURRENTLY WORKING/VOLUNTEERING? ☐ Yes ☐ No ☐ Retired ☐ Student ☐ Disability

OCCUPATION?

HOW MUCH DO YOU DRINK? _____ drinks/week

HOW MUCH DO YOU SMOKE? ☐ Current (every day) ☐ Current (occasional) ☐ Former smoker ☐ Never a smoker

RECREATIONAL DRUG USE? ☐ Yes ☐ No

WEIGHT

HEIGHT

HAVE YOU HAD A BONE DENSITY? **IF YES, WHEN?** _____

REASON FOR APPOINTMENT

_____

_____

HAVE YOU HAD X-RAYS FOR TODAY'S CONDITION? ☐ Yes ☐ No

If yes, at what facility were they done? _____

***** If you have a copy with you, please give to the receptionist*****

NSAIDS/BLOOD THINNERS (please circle Yes or No):

Coumadin	**Yes No**	Motrin	**Yes No**	Mobic	**Yes No**
Plavix	**Yes No**	Lodine	**Yes No**	Relafen	**Yes No**
Xarelto	**Yes No**	Aleve	**Yes No**	Diclofenac	**Yes No**
Aspirin	**Yes No**	Naproxen	**Yes No**	Etodolac	**Yes No**
Celebrex	**Yes No**	Excedrin	**Yes No**	Ibuprofen	**Yes No**
Prednisone or other steroid	**Yes No**				

NSAIDS/BLOOD THINNERS Other (please add any not listed above):

REVIEW OF SYSTEMS (please circle Yes or No):

Weight Change	**Yes No**	Chronic Cough	**Yes No**	Anesthesia problems	**Yes No**
Swollen feet/ankles	**Yes No**	Chronic Diarrhea	**Yes No**	Depression/anxiety	**Yes No**
Seizures	**Yes No**	Swollen lymph nodes	**Yes No**	Rapid heartbeat	**Yes No**
Dry eyes	**Yes No**	Chest Pain	**Yes No**	Joint/muscle pain	**Yes No**
Skin rash	**Yes No**	Jaundice	**Yes No**	Easy bleeding/bruising	**Yes No**
Neck Pain	**Yes No**	Back Pain	**Yes No**	Joint problems	**Yes No**
Urinary Urgency	**Yes No**	Constipation	**Yes No**	Night sweats	**Yes No**

Please answer all of these questions as accurately as possible. If you do not understand the questions, please ask for assistance.

The information above is complete to the best of my knowledge.

Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF AWARENESS OF NOTICE OF PRIVACY PRACTICES

By signing this form I acknowledge being informed of Sports Medicine North Orthopaedic Surgery Inc.'s **Notice of Privacy Practices**. A copy of the notice is posted in the office and is available to me upon request. This notice provides me with detailed information about how Sports Medicine North Orthopaedic Surgery, Inc. may use and disclose my protected health information for the purposes of treatment, payment and health care operations.
I also understand that is Sports Medicine North Orthopaedic Surgery, Inc. amends its **Notice of Privacy Practices** a copy of the revised Notice may be obtained by contacting that office at (978) 818-6350 or viewing it online at www.sportsmednorth.com/privacy . Patients will be informed of any amendments to this notice upon registering for an appointment.
I have the right to request, in writing, that of Sports Medicine North Orthopaedic Surgery, Inc. restricts how they use and disclose my protected health information for the purposes of treatment, payment of health care operations and that the Practice is not required by law to grant my request. However, if the Practice does decide to grant my request, the Practice must adhere to the approved restrictions unless it is an emergency situation or it is in direct conflict with state or federal laws and regulations.

SPORTS MEDICINE NORTH ORTHOPAEDIC SURGERY PATIENT DISCLOSURE LETTER

Many of your surgeons have been active in their career with research and development of new implants and improved surgical instruments and techniques. As part of their work, they have worked under contracts with orthopaedic companies, providing consulting services on new products and input on research and development. In addition, many surgeons have given instructional lectures on implants and surgical techniques for other doctors and medical personnel. In return for this time and expertise, they have been paid a consulting fee. They receive **no** compensation from any companies for drugs or devices used in patient care.

It is important to our office that you are aware of these relationships with implant manufacturers, that our office puts the interests of patients first, and that we are available to answer any questions that you may have. These disclosures are subject to change, please see a receptionist for the latest version or on our website – www.sportsmednorth.com/disclosure

Patient's Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____
(please print)

Signature of Legal Representative: _____

Print Name: _____ Date: _____

Relationship of Representative to the Patient: _____

Sports Medicine North
ORTHOPAEDIC SURGERY, INC

Patient Name:_____

GE EMR ID #:_____

Date:_____

Medication/Narcotics Policy

The purpose of this agreement is to prevent any misunderstandings regarding medications you may be taking for pain control, muscle relaxation or other reasons while under our care here at Sports Medicine North. This outline is to help both you the patient and your physician to comply with the laws regarding controlled pharmaceuticals.

I understand this agreement is essential to the trust and confidence necessary for an appropriate doctor/patient relationship.

Your treating physician may prescribe you narcotic pain medication to address your clinical problem for a brief period of time after your injury, surgery or interventional procedure. Your primary care physician will ultimately manage your medication regimen. It is best that one physician oversee the management and prescribing of your medications, this prevents any confusion regarding dosing, interactions and refilling intervals. Our office is not a chronic pain management clinic. We will, however, be happy to discuss your regimen and offer suggestions as necessary with your primary care provider.

Narcotics are highly addictive pain medications that can create side effects such as lethargy, drowsiness, dizziness, lightheadedness, fainting, altered consciousness, sedation, slowed reflexes, slowing of respiratory rate, physical dependence, addiction and constipation. Abrupt discontinuation of these medications may result in withdrawal symptoms. Due to these potential side effects, you should not drive or operate heavy machinery, operate a motor vehicle, work in hazardous areas or be responsible to care for another individual who is unable to care for himself/herself while taking these medications. You could cause harm to yourself or others.

Many narcotics, such as Percocet and Vicodin contain acetaminophen (Tylenol), which if taken in high doses can cause liver failure and even death. Narcotics need to be taken only as directed and used with caution due to tolerance or addictive properties.

You must take your medication only as prescribed. Supplementation, early refilling of your prescription, requesting prescriptions from any other physician or practice, prescriptions taken from family or friends, overuse or abuse of medications subjects you to immediate dismissal from the practice.

Continued on next page

SMN Medication/Narcotics Policy continued

If you are to have a prescription refilled from our office, you may need to make an appointment during standard business hours. This allows you to meet and discuss your condition with a physician before running out of your medications.

Prescriptions will not be filled outside of normal business hours. The physician or covering staff may not know you or your condition. In order to prevent mishaps we will only refill medications during normal business hours when your medical records are easily accessible. The office is open Monday-Friday 8am-5pm, except holidays.

If you are presenting to the clinic for a medication change you need to bring the remainder of your previous prescription in with you for proper disposal. If you cannot come in for an appointment for a refill, your pain symptoms have greatly worsened and you cannot see your primary care physician we recommend that you be seen at a local emergency room or a local hospital for evaluation and treatment.

In addition, I agree to the following,

- If addictive behavior occurs, I agree to be discharged, and agree to be referred or seek care immediately from an addiction specialist or psychiatrist and will follow prescribed treatments including detoxification if recommended.
- I understand the goal of this therapy is to decrease pain and increase my ability to work and function thereby improving my quality of life.

You will be discharged from the Practice if you break any of the following rules or at the discretion of the physician:

- Use more medication than prescribed (run out early).
- Get pain medicine from any other person or physician not authorized by your Sports Medicine North physician.
- Use the medication in a way that it was not prescribed.
- Exhibit deceitful behavior or provide false information.
- Attempting to obtain medication with implausible excuses.
- Make repeated calls to the office or after hours to obtain medication.
- Use multiple pharmacies without my physician's knowledge.
- Sell or give your medications to another person.
- Alter a prescription.

I, _____, acknowledge that I have read both pages of the Sports Medicine North Medications Narcotics Policy and I agree to comply with these rules. I understand that failure to follow these rules will result in my being discharged from the practice and risk prosecution as directed by state and federal laws.

_____ _____

Patient Signature Date

Version: 4/2010

SMN EMR Patient Portal Authorization Form

Patient ID (Office Use Only): _____

Patient Name (please print clearly): _____ DOB: _____

E-mail address (please print clearly): _____

(Note: We suggest you use a personal E-mail address)

Purpose of this Form:

The patient portal is designed to enhance secure patient-physician communications and is provided as a courtesy to our valued patients. If there is persistent abuse or negligence with the use of the patient portal, we reserve the right at our own discretion to terminate offering patient portal, suspend user account, or modify services offered through the patient portal. Please read this form thoroughly before signing.

How the SMN EMR Patient Portal Works:

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information or attachments. Secure messages and information can only be read by someone who knows the right password to log into the portal site. Once you are logged into the portal you will have access to only your records or those of whom you are legally responsible.

Via the SMN EMR Patient Portal you will be able to:

- Use the messaging function to communicate with clinic staff (Non-emergent only)
- Request a copy of an office note
- Request a medication refill (Narcotic requests will not be accepted) **(To be released at a later date)**
- Print or save an electronic copy of the health summary and update medical information if needed **(To be released at a later date)**

Response time:

- We will respond to non-urgent portal inquiries within 3 business days
- Prescription refills are addressed within 2 business days after receiving request

The Patient Portal is NOT intended for the following:

- **NO** diagnosis or treatment is offered by portal email. Diagnosis can only be made and treatment rendered after the patient schedules and is SEEN (face-to-face encounter) by the physician or physician assistant.
- **NO** emergent communications or services. Go to the nearest emergency room or dial 911
- **NO** request for NARCOTIC pain medication will be accepted

Protecting Your Private Health Information and Risks:

This method of communicating and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two important factors, we need you to make sure we have your correct email address and you must inform us if it ever changes. We strongly suggest that you use a personal email account rather than a work email address. You need to keep unauthorized persons from learning your password. If you think someone has learned your password, you should promptly change it via the patient portal.
We understand the importance of privacy with regard to your health care and will continue to protect the privacy of you medical information. Our use and disclosure of medical information is described in our Notice of Privacy Practices.

Patient Name:_____ DOB: _____

Conditions of Participating in the Patient Portal

Access to the secure web portal is a service, and we may suspend or discontinue it at any time and for any reason. If we do suspend or discontinue this service we will notify you as promptly as we reasonably can. You agree to not hold Sports Medicine North or any of its staff or physicians liable for network or security infractions beyond their control. By signing this agreement, you acknowledge that you understand the policies and procedure, agree to comply with them and all of your questions have been answered to your satisfaction. If you do not understand, or do not agree to comply with our policies and procedures, do not sign this agreement and do not request a username and password.

Parents of Minors

Please note all patient portal accounts for minors will deactivate upon the patient reaching the age of 18. The patient (after reaching their 18th birthday), will have the option to re-sign up for a portal account using their own email address.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of patient portal and agree that I understand the risks associated with online communication between my physician and patient, and consent to the conditions outlined herein. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from Sports Medicine North, should I decide against using the patient portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for the online communications. I also understand that the information to be released may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, sexually transmitted infections including HIV or AIDS, test results, and developmental disabilities. I have been proactive about asking questions related to this consent agreement. All of my questions have been answered with clarity.

Standardized Clinical Summaries

Due to government mandated reporting, our office must make available to you a standardized clinical summary of your office visit. Because of our internal software configurations, our standardized clinical summaries provide limited relevant information regarding your visit, therefore you have the option to decline this summary by selecting the box below:

☐ **I decline receiving the automated standardized clinical summary. I understand that I will be able to request a more thorough office visit note through the patient portal.**

Patient/Guardian Signature_____ Date: _____

For Office Use Only **Patient ID** _____

I have authenticated the identity of the person named on this authorization form:

☐ Picture ID ☐ Person known to me ☐ Other (specify) _____

Employee Initials_____ Date:_____