BAY CITY ORTHOCARE LLC

PATIENT MEDICAL HISTORY

This PATIENT MEDICAL HISTORY form must be completed annually by the patient or a legal guardian. These questions are designed to help us give you the best possible care during your visit.

Name _____ Sex _____ Age _____ Date of Birth _____
(Please PRINT on all lines)

Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell ( ) _____

Referring Physician _____ Family Physician _____ Ht _____ Wt _____

Emergency Contact: Name _____ Phone _____

Treating Physician for Diabetes: _____ **Phone** _____

Reason for today's visit: _____

Please answer the following questions:	YES	NO
1. Do you have any allergies to any type of materials?	☐	☐
2. Do you have any current skin problems (rashes, blisters, fungus, itching, bruises, etc.)?	☐	☐
3. Do you use any special protective or corrective equipment or devices that aren't usually used for your level of activity (knee brace, foot orthotics, ankle brace, or other device)?	☐	☐
4. Do you currently have any internal fixation devices from a previous or current fracture? (If yes, please explain below when & where the fixater was placed)	☐	☐
5. Do you currently have problems with pain or swelling in muscles, tendons, bones, or joints? (If yes, please explain below)	☐	☐
6. Are you now, or have you ever been treated for Hepatitis B?	☐	☐
7. Are you now, or have you ever been treated for Tuberculosis?	☐	☐
8. Have you ever, or do you currently have numbness or tingling in your arms, hands, legs, or feet?	☐	☐

9. Have you ever, or are you currently being treated for one or more of the following:
(please check all that apply)

☐ Diabetes	☐ Lymphedema	☐ Bleeding/clotting problems	☐ Cancer
☐ Depression	☐ Infection	☐ Circulation problems	☐ HIV/AIDS
☐ Stroke	☐ Heart Attack	☐ High Blood Pressure	☐ Foot Ulcer

Explain any other relative medical condition that we should know about: _____

_____

_____

Are you currently taking any prescription medications that could cause you to feel dizzy or drowsy, which can lead to a fall? ☐ YES ☐ NO

Describe Last Fall:
☐ Fell, but did not seek medical attention (Low) Date: _____
☐ Fell, went to the doctor but not hurt seriously (Medium) Date: _____
☐ Fell, required admission to the hospital (High) Date: _____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Patient or Authorized Representative Signature _____

Date: _____ Relationship to Patient _____

Over →

Information unchanged _____ Initial Date ____/____/____ Information unchanged _____ Initial Date ____/____/____

CONSENT FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I understand that any information obtained from or about me during the course of, or as the result of, the physician-patient relationship, may be used and/or disclosed by Bay City OrthoCare, LLC for purposes of carrying out treatment, obtaining payment, or carrying out other health care operations.

I have been provided a copy of the Bay City OrthoCare, LLC Notice of Privacy Practices which I understand. I also understand that the terms of the Notice of Privacy Practices may change in the future and that I may obtain a copy that is in effect at any given time by requesting a copy from Bay City OrthoCare, LLC.

I understand that I have a right to request that Bay City OrthoCare, LLC, restrict how my health information is used or disclosed to carry out treatment, payment and/or other health care operations, but that Bay City OrthoCare is not required to agree to any such request. I understand that, if such a request is agreed to, that restriction will be binding on Bay City OrthoCare, LLC.

I understand that I have a right to revoke this consent by providing a written revocation of this consent to Bay City OrthoCare. I also understand that, if I choose to remove my consent, it can only be revoked to the extent that Bay City OrthoCare, LLC has not acted in reliance upon the consent.

By signing below, I hereby voluntarily and knowingly consent to allow Bay City OrthoCare, LLC and any of its employees and/or agents, to use and/or disclose my health information as deemed appropriate to carry out treatment, payment or health care operations of Bay City OrthoCare, LLC.

Dated _____ X _____

(signature of patient or legal representative)

If you are the legal representative of the patient, please check off the basis for your authority:

( ) Power of Attorney (attach copy)

( ) Guardianship Order (attach copy)

( ) Parent of Minor

( ) Other _____