Dr. Steven Stahle

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I.: _____

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Cell: _____ Marital Status: _____

Social Security #: _____ Date of Birth: _____ Gender: _____

Employer/Occup: _____ Employer Phone: _____ Email: _____

Race: ____Black ____White ____Asian ____American Indian ____Native Hawaiian or Other Pacific Islander ____Other

Ethnicity: ____Hispanic/Latino ____Not Hispanic/Latino Preferred Language_____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: _____

HEALTH INSURANCE INFORMATION - A Copy of Your Health Insurance Card(s) is Required

PRIMARY Coverage

Insurance Company: _____

Subscriber/Card Holder/Policy Owner: _____

Subscriber's Date of Birth: _____

Subscriber's Relationship to Patient: _____

SECONDARY Coverage

Insurance Company: _____

Subscriber/Card Holder/Policy Owner: _____

Subscriber's Date of Birth: _____

Subscriber's Relationship to Patient: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

How did you hear about our office: _____

Pharmacy Name: _____ Phone: _____

Mail Order Pharmacy: _____ Phone: _____

AUTHORIZATION

I hereby authorize this office to furnish information to insurance carriers including Medicare and Medicaid concerning this illness/accident and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance or workers compensation. I hereby authorize photocopies of this authorization form to be valid as the original. I consent to disclosure of my medical information to outside agencies for the purpose of providing healthcare services to me. If I fail to obtain a referral, I understand that I am financially responsible. I acknowledge that I have received the mandatory information regarding " Notice of Privacy Practices." (HIPAA)

X SIGNATURE _____ **Date** _____

AUTHORIZATION TO RELEASE INFORMATION (Your Signature Is Required)

Do You Authorize Another Person To Receive Your Medical Information? Yes ☐ No ☐

If YES, Who: _____ Relationship to Patient _____

Do You Authorize Another Person To Receive Your Billing Information? Yes ☐ No ☐

If YES, Who: _____ Relationship to Patient _____

Do You Authorize Professional Athletic Orthopedics, LLC or Kirkwood Diagnostic & Orthropedic Associates, LLC To Leave Patient Test Results on an Answering Machine or Voice Mail: Yes ☐ No ☐

If YES, at which phone number(s)? _____

X SIGNATURE _____ **Date** _____

Date _____

Name _____

Age _____

DOB _____

Is visit due to a work related injury? Yes ☐ No ☐ Is visit due to an automobile accident? Yes ☐ No ☐

Patient's Height: _____ Patient's Weight: _____

REASON FOR TODAYS VISIT

Date symptoms began: _____ Body Part: _____ (RT/LT/Both)

Describe problem: _____

If injured, what makes it worse? _____

If injured, what makes it better? _____

Have you had similar symptoms prior to this visit? _____

Have you seen another physician for this problem? _____

If so, which physician: _____ Dates of care: _____

Was surgery performed? _____ Date: _____ Did the problem resolve? _____

Do you exercise? Yes ☐ No ☐ Brief description of activities _____

PAST MEDICAL HISTORY

	No	Yes		No	Yes		No	Yes
Stroke or TIA			Paralysis			Emphysema		
Heart Attack			Numbness (Hands/Feet)			Asthma		
Heart Murmur			Athritis DJD			Tuberculosis		
Mitial Valve Prolapse			Head or Spine Injury			Diabetes		
High Blood Pressure			Back Pain or Injury			Cancer		
High Cholesterol			Ulcers			Type of Cancer:		
DVT or Blood Clots			Hypothyroid			COPD		
Bleeding Tendencies			Epilepsy			HIV		
Anemia			Hepatitis - What Type			Kidney Disease		
Skin Cancer			Seizures			Seasonal Alergies		
Sleep Apnea			Asthma					

FAMILY HISTORY (Check all that apply.)

☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ High Blood Pressure

☐ Cancer ☐ Kidney Disease ☐ Anesthesia Problems ☐ Other _____

PAST SURGICAL HISTORY

Surgeries/Hospitalizations:	
1.	5.
2.	6.
3.	7.
4.	8.

Check box if list continues ☐

Have you ever had a problem with Anesthesia? Yes ☐ No ☐

Explain: _____

Do you require antibiotics prior to dental/medical procedures? Yes ☐ No ☐

SOCIAL HISTORY

Tobacco Use: ☐ No ☐ Yes, Packs per day? _____ for _____ Years ☐ Stopped - When? _____

Daily Alcohol Use: ☐ No ☐ Yes, Amount? _____ Caffeine: ☐ No ☐ Yes, Amount? _____

ALLERGIES/TYPE OF REACTION

VACCINATIONS

Date of last tetanus shot _____

REVIEW OF SYSTEMS

	No	Yes		No	Yes
Weight Loss			Vomiting of Blood		
Fever and/or Chills			Any Change in Bowel Habits		
Double Vision			Heartburn		
Loss of Vision			Difficult Urination		
Loss of Hearing			Pain or Burning on Urination		
Severe Nose Bleeds			Blood in Urine		
Hoarseness			Frequent Urge to Empty Bladder		
Frequent Sore Throats			Loss of Urine when Laughing, Coughing, etc.		
Shortness of Breath with Exertion			Weakness		
Swelling of Feet or Ankles			Frequent Itching		
Sudden Changes in Rate of Heart Beat			Rashes		
Pain or Pressure in Chest with Exertion			Numbness/Tingling		
Awakened at Night Short of Breath			Memory Loss		
Chronic Cough			Balance Problems		
Coughing up Blood			Do you Worry a Lot?		
Frequent Chest or Bronchial Infections			Are you a Nervous Person?		
Nausea or Vomiting			Are you Frequently Unhappy or Depressed?		
			Excessively Thirsty, Hot, Cold, Sleepy		

Refer to back

MEDICATIONS LIST

(This includes vitamins, supplements and all over the counter medicines including anti-inflamatories)

This is a Federal Government Policy mandated under Health Care Reform.

This list must be completed in its entirety for every visit (or you must bring ALL medications with you) or the physician will not be able to see you.

Patient Name_____ **Date of Birth**_____ **Date**_____

Name	Dose/MG	Frequency/Times Per Day

Dr. Steven Stahle

E-PRESCRIBING CONSENT FORM

ePrescribing is defined as a physician's ability to send accurate, error free and understandable prescriptions directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 lists standards that must be included in an ePrescribe program. These include:

- Formulary and benefit transactions – Gives the prescriber the information about which drugs are covered by the drug benefit plan.
- Medication history transactions – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification- Allows the prescriber to receive an electronic notice from the pharmacy notifying them that the patient's prescription has been picked up, not picked up, or partially filled.

By Signing this consent form, you are agreeing that Motion Orthopaedics Kirkwood may request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for the purpose of treatment.

Understanding all of the above, I hereby provide informed consent to Motion Orthopaedics Kirkwood to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Signature Date