Tennessee Sports Medicine Group A SquareOne Practice

Square One Personalized Restorative Health

Tennessee Sports Medicine Group/SquareOne
2260/2270 Sutherland Avenue Knoxville, TN 37919
phone 865-951-2975/865-219-5926 fax: 865-951-2972

Today's Date: _____ How did you hear about us? _____

PATIENT INFORMATION

Name (Last, First, MI): _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Home Cell Work Email: _____

Gender: M / F Marital Status: Married / Other / Single

Social Security: _____ Date of Birth: _____

Student Status: Full / Part / Non-Student Employer Name: _____

Referred By: _____

Ethnicity: Hispanic or Latino / Other Preferred Language: _____

Race: Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White

Smoking Status: Daily / Occasional / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____ Home: _____ Cell: _____

Relationship to Patient: Spouse / Child / Parent / Other:

Primary Care Physician: _____ Phone: _____

FINANCIAL INFORMATION

Insurance Worker's Comp Self-Pay (Cash) Personal Injury/Auto Other: _____

Primary Insurance

Name: _____

Relation to insured: _____

Insured's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

Secondary Insurance

Name: _____

Relation to insured: _____

Insured's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

Who is responsible for payment? Self / Other (relationship):

Name (Last, First, MI): _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

IT IS USUAL AND CUSTOMARY TO PAY FOR SERVICES AS RENDERED UNLESS OTHERWISE ARRANGED.

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PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Began (Date): _____ Describe how it began: _____

_____

_____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

Quality of the Complaint/Pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff and Sore

Other: _____

How frequent is the complaint Present? Off and On / Constant

Does this complaint radiate/shoot to any areas of your body? NO / YES

Head – Base of Skull / Forehead / Sides – Temple R / L / Both

Leg – Hop / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm – Across Shoulder / Elbow / Hand – Fingers R / L / Both

Other Area: _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected by this condition? _____

For this CURRENT condition, have you:

Received any other treatment? None / DC / MD / PT / Massage / ER / Other: Where? _____

Had any previous Surgery or Interventions in this area? _____

Taken any Medications? OTC / Prescription

Had any diagnostic testing? X-rays / MRI / CT / Other: When and Where? _____

Describe any Secondary Complaints: _____

HEALTH HISTORY (Please use the reverse side of this page if additional space is needed)

Current Medications (List): _____

_____

Allergies to Medications (List): _____

_____

Past Health History

Surgeries (Date, Type, Reason): _____

_____

Major Injuries/Trauma: _____

_____

Major Hospitalizations: _____

_____

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Are you currently experiencing any of these symptoms?
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue

Musculoskeletal
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones
- ☐ Other: _____

Neurological
- ☐ Numbness or Tingling
- ☐ Loss of Feeling
- ☐ Dizziness or Light Headed
- ☐ Frequent Headaches
- ☐ Convulsions/Seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Head Injury
- ☐ Auto Accident
- ☐ Other: _____

Mind/Stress
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: _____

Genitourinary:
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/strain w/Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: _____

Gastrointestinal
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movement
- ☐ Nausea/Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: _____

Cardiovascular/Heart
- ☐ Chest Pain
- ☐ Rapid or Heartbeat Changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Extremities
- ☐ Heart Problems
- ☐ Other: _____

Respiratory
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other: _____

Eyes/Vision
- ☐ Wear Contacts/Glasses
- ☐ Blurred/Double Vision
- ☐ Glaucoma
- ☐ Eye Disease/Injury
- ☐ Other: _____

Ears/Nose/Throat
- ☐ Bleeding Gums/Sores
- ☐ Bad Breath/Taste
- ☐ Dental Problems
- ☐ Swollen Throat/Voice Change
- ☐ Swollen Gland in Neck
- ☐ Ringing in the Ears
- ☐ Ear Ache/Drainage
- ☐ Sinus/Allergy Problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other: _____

Endocrine/Hematologic/Lymphatic
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Excessive Thirst/Urination
- ☐ Cold Extremities
- ☐ Heat/Cold Intolerance
- ☐ Change in Hat/Glove Size
- ☐ Dry Skin
- ☐ Glandular/Hormone Problem
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise/Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune System Disorder
- ☐ Other: _____

Skin and Breasts:
- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Non-Healing Sores
- ☐ Change of Appearance of a Mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other: _____

Women Only:
Are you pregnant?
Yes – Due Date _____
No – Date of Last Menstrual Period
_____

- ☐ Infertility
- ☐ Painful or Irregular Periods
- ☐ Vaginal Discharge/Dryness
- ☐ Mood Swings
- ☐ Other: _____

Pregnancies with Outcome and Date:
_____
_____
_____

Comments: _____
_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

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Patient Name: _____ Date: _____

Appointment Reminders and Health Care Information Authorization

At times our office may need to contact you with appointment reminders, information about treatment, or other health related information. By signing below, you are giving us authorization to contact you with these reminders/information and understand that

(Please place a line through any method that you REFUSE to be contact by and initial.)

I may be contacted by: Phone (home or work), Cell Phone, Email, or Postcard.
Email Address: _____

Messages may be left: Answering Machine/Voicemail at Home, Work, and on Cell Phone.
Individuals answering my phone at home or work.

I authorize the following person(s) to receive the protected health information

Name: _____ Phone: _____
(*please print*)

Information that we use or disclose based on this authorization may be subject to re - disclosure by anyone who has access to the reminder or information and may no longer be protected by the federal privacy rules.

You may restrict the individuals or organizations to which your health care information is released, or revoke your authorization at any time; however, the revocation must be in writing and will become effective once we receive the revocation. If you are required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contact any of your claims.

You have the right to refuse any part of this authorization without affecting your treatment or the methods use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

I authorize the use or discloser of my health information as described above. This notice is effective as of the date above and expires seven years from the date I last received services in this office.

_____ _____
Patient Signature Authorized Provider Representative

_____ _____
Personal Representative Printed Personal Representative Signature

_____
Description of personal representative's authority to act for the patient

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully.

Tennessee Sports Medicine Group/SquareOne Legal Duty

Tennessee Sports Medicine Group/SquareOne is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

Uses and Disclosures of Health Information

Tennessee Sports Medicine Group/SquareOne uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administration activities and evaluating the quality of care that we provide. For example, Tennessee Sports Medicine Group/SquareOne may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. Tennessee Sports Medicine Group/SquareOne may use or disclose your personal health information without prior authorization for public health purposes, for research studies, for auditing purposes, and for emergencies. We also provide information when required by law.

In any other situation, Tennessee Sports Medicine Group/SquareOne policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop further disclosures at any time.

Tennessee Sports Medicine Group may change its policy at any time. When changes are made, a new Notice of Patient Information Practices will be posted in the waiting room and patient treatment areas and will be provided to you at your next visit. You may also request a copy of Notice of Patient Information Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a lit of instances where we have disclosed your personal information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Tennessee Sports Medicine Group/SquareOne will consider all requests on a case-by-case basis, but the practice is not legally required to accept them.

Concerns and Complaints

If you are concerned that Tennessee Sports Medicine Group/SquareOne may have violated your privacy rights, or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our manager. You may also send a written complaint to the US Department of Health and Human Services.

I have read and fully understand Tennessee Sports Medicine Group/SquareOne Notice of Information Practices. I understand that Tennessee Sports Medicine Group/SquareOne may use or disclose my personal health information for the purpose of providing treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Tennessee Sports Medicine Group/SquareOne will consider restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information as noted in Tennessee Sports Medicine Group/SquareOne Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient Name

_____ _____

Patient Signature / Child's Name (minor) Date

2260/2270 Sutherland Avenue Knoxville, TN 37919
Phone: 865-951-2975 Fax: 865-951-2972

Medical Records Release Form

By signing this form, I authorize the release of confidential health information by providing a copy of my medical records, summary or narrative of my protected health information to Tennessee Sports Medicine Group/SquareOne

_____ _____

Patient Name Date of Birth

The Information you may release subject to this signed release form is as follows:

Treatment Record	Operative Report	Radiology Reports
Care Plan	History and Physical	Lab Reports
Protocol	Pathology Reports	Medication Records

Other: _____

Release my protected health information from the following physician/facility:

Physician/Facility Name: _____

Physician Fax No.: _____

_____

Signature of Patient/Guardian

_____

Signature of Office Representative