Medical Exam Date: _____ **PT Eval Date:** _____

Name: _____ **Gender:** M F **Birth Date:** _____/_____/_____

Address: _____ **City, State, Zip** _____

Home Phone: ( ) _____ **Mobile:** ( ) _____

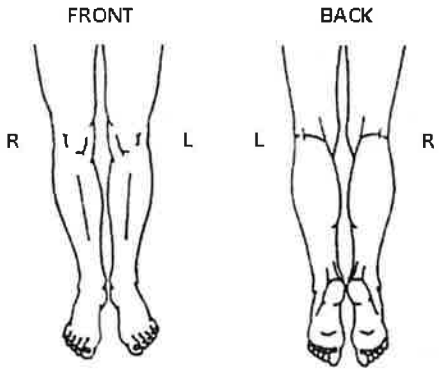
Email Address: _____ **SSN #:** _____ - _____ - _____

Marital Status: S M D W **Occupation:** _____ **Referred to AWSC by:** _____

Emergency Contact: _____ **Phone:** ( ) _____ **Relationship:** _____

HPI - KNEE COMPLAINT

Please check ALL that apply for each question below.



WHICH KNEE: ☐ BOTH ☐ Left ☐ Right

When did it first start? _____

INJURY: ☐ None **Date:** _____

SYMPTOMS: • • • ☐ Stiff or Achy ☐ Cracking/popping sounds

☐ Pain/Throbbing ☐ Unsteadiness ☐ Weakness ☐ Buckling

☐ Use rail on stairs ☐ Cane/walker ☐ Other

_____

WHAT AGGRAVATES SYMPTOMS?

☐ Standing ☐ Walking ☐ Stairs ☐ Driving ☐ Prolonged Positioning

☐ Sitting ☐ Rising from sitting ☐ Sleep ☐ Humidity ☐ Cold

• • • **DOES COMPLAINT(S) INTERFERE WITH:** _____

☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine ☐ Exercise ☐ Household duties

WHAT HAS GIVEN SOME RELIEF IN THE PAST? _____

☐ Walking/Exercise ☐ Therapy ☐ Brace ☐ Rest ☐ Injections ☐ Pain medicines ☐ Hot/cold packs

PREVIOUS KNEE INJECTIONS: ☐ N/A

• ☐ Steroid/Cortisone: **Left Right** When: _____

☐ Visco Supplement: **Left Right** When: _____

• • • **PLEASE CIRCLE YOUR <u>WORST</u> PAIN LEVEL IN THE PAST COUPLE DAYS:**

(Mild) **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** (Severe)

• **PHYSICAL THERAPY/EXERCISE:** ☐ Yes ☐ Never

If yes, Where? _____ When? _____

How long did it help? _____

KNEE BRACING: ☐ I have been prescribed a brace ☐ I purchased my own brace ☐ I **DO NOT** have a brace

CURRENT MEDICATIONS: ☐ N/A

_____ _____ _____ _____

_____ _____ _____ _____

• • • **Have you ever taken any of the following:**

☐ Advil ☐ Ibuprofen ☐ Asprin/Excedrin ☐ Aleve/ Naproxen ☐ Mobic/Meloxican ☐ Celebrex

☐ Tylenol ☐ Tramadol ☐ Naposyn/Naproxen ☐ Etodolodac ☐ Diclofenac ☐ Arthrotec

MEDICINE ALLERGIES: ☐ N/A

_____ _____ _____ _____

INSURANCE INFORMATION

I clearly understand that all insurance coverage, whether accident, work related, or general health coverage is an arrangement between my insurance carrier and myself. I understand that if this office chooses to bill any services to my insurance carrier they are performing these services strictly as a convenience to me. Advanced Spine & Wellness Center will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid claims or balances.

I understand that there may be some services that my insurance company will not cover. If my insurance company notifies me that they are refusing payment for any services I have received, I will contact Advanced Spine & Wellness Center immediately to notify them of the nonpayment/rejection notice. I authorize the assignment of all insurance benefits to be directed to Advanced Wellness Systems, LLC (d/b/a Advanced Spine & Wellness Center) for services rendered.

Patient's Signature _____ Date _____

Parent/Guardian's Signature _____ Date _____

Who should receive charges on your account?

☐ Health Insurance ☐ Medicare ☐ Auto Insurance ☐ Workers' Compensation

☐ Patient ☐ Spouse ☐ Parent/Guardian

Name of Insurance Co. _____ Policy # _____

Policyholder information (if different from patient)

Insured's Name _____ Insured's Birth Date ____/____/____

Patient's Relationship to Insured _____ Insured's SS # (optional) _____

Do you have a secondary or supplemental insurance policy? ☐ Yes ☐ No

Secondary Insurance Co. _____ Policy # _____

If auto accident or work injury:

Accident Location (City & State) _____ Date of Injury ____/____/____

Which auto insurance should be billed for medical claims?
If you have a **Maryland** policy, we must bill the vehicle owner's insurance or your auto insurance, NOT the at-fault party's.
If you have a **Virginia** policy, we must bill your auto insurance or the vehicle owner's insurance, NOT the at-fault party's.
If you have a **DC** policy, we must bill your health insurance first; then your auto insurance if the accident happened outside DC.
Please note: We cannot bill the at-fault party's auto insurance; we are required to bill your auto insurance or health insurance.

Insurance Carrier _____ ☐ patient's insurance ☐ vehicle owner's

Claim # _____ Policy State _____

Adjuster _____ Phone # _____

Mailing Address _____ Fax # _____

Personal Injury Protection (PIP) or Med-Pay Policy Limit $_____ Used $_____

Do you have an attorney on your case? ☐ Yes ☐ No

Attorney _____ Phone # _____

Mailing Address _____ Fax # _____