675 Old Ballas Road, #100 / Creve Coeur, MO 63141
phone 314.733.9009 / fax 314.733.9008

PATIENT INTAKE FORM

DEMOGRAPHICS

Last Name: ______________________ First Name: ______________________ MI: ______

Home Address: ____

DOB: _____/_____/_____ SSN: ______________________ Employer: ______________________

Email Address: ____

Did you bring X-Rays/ MRI with you today? ☐ Yes ☐ No ☐ N/A

EMERGENCY CONTACT

Emergency Contact: ______________________ Relationship: ______________________

Emergency Contact Phone: ______________________ Cell Home Work

PRIMARY CARE PHYSICIAN AND PHARMACY

PCP: ______________________ PCP Phone: ______________________

PCP Address/ Practice Location: ____

Preferred Pharmacy: ______________________ Phone: ______________________

MEDICATIONS AND ALLERGIES

Do you have a metal allergy? ☐ Yes. What metal? ______________ ☐ No ☐ Unknown

List any **Allergies:** ☐ No Known Allergies

____

____

List your **Current Medications:** Include Prescriptions, OTC medicines, Supplements/ Vitamins, etc. If you have a medication list with you today, the Front Desk can make a copy for you to include with this form.

Medication	Dosage	Frequency

Saint Louis Orthopedics and Sports Medicine

Name: ____DOB ___ /___ /____

What are we seeing you for today? Who referred you? ________________

____ ____Right ____Left ____Both

____

____

How long have you had this problem? ________________________________

Did you have an injury? ____________________ Date of injury: ___/ ___/ _____

Were you hurt at work? ____Yes ____No Active work comp claim? Y N

What activities make you have more symptoms? ____________________

____

What treatments have you had before today?

___Anti-inflammatory medicine ____Cortisone shots ____ Lubricant shots

___Physical therapy ____Stem cells ____PRP injections ____CBD/THC

___Massage therapy ____Topical gels or creams ____Braces ____Narcotic medications

___Arthroscopic surgery ___Joint replacement surgery____________Other surgery (please list)

What tests have you had before today for this problem?

____X-rays ____MRI ____CT scan ____Nerve conduction ____Ultrasound

Do you have any of the following medical conditions?

___ Heart attack/myocardial infarction ___ Congestive heart failure

___ Peripheral vascular disease/ abdominal aneurysm

___ Stroke or TIA ___Dementia

___Blood clots/DVT ____Pulmonary embolism ____Blood clotting abnormality ____ Take blood thinners

___ COPD

___ Connective tissue disease /Lupus / Rheumatoid arthritis /Fibromyalgia

___Are you on any disease modifying drugs?

___ Peptic ulcer disease

___ Diabetes ____Do you take insulin Y N ___ Chronic kidney disease

___ Urinary retention / prostate disease

___ Cancer ___Leukemia ___ Lymphoma

___AIDs/HIV ___ Staph infections /MRSA ____Chronic dental problems/ infections

___ Obesity

Signature:____Date ___/___/____

BJC Medical Group

Name: ______________________

DOB: ______________________

Receipt of Notice of Privacy Practices

Initial _____ I acknowledge I have received or I have been provided the opportunity to receive a copy of BJC's Notice of Privacy Practices that explains when, where and why my protected health information may be used or shared by BJC Medical Group.

Patient Communication Preferences

Phone number for voice message(s): ______________________

Cell number for text message(s): ______________________

Email address: ______________________

HIPAA Disclosure Authorizations(s) – Initial authorize OR do not authorize below

Initial _____ I authorize BJC Medical Group to provide the following person(s) with my protected health information:

Print Name: ______________________ Relationship to Patient/Phone number: ______________________

Print Name: ______________________ Relationship to Patient/Phone number: ______________________

Initial _____ **I <u>do not</u> authorize BJC Medical Group to:**

Disclose my protected health information to anyone other than myself, except as permitted by HIPAA and as described in BJC's Notice of Privacy Practices.

Prescription Authorization

Initial _____ I authorize BJC Medical Group to allow the following person(s) to pick up prescriptions on my behalf:

Print Name: ______________________ Relationship to Patient: ______________________

Print Name: ______________________ Relationship to Patient: ______________________

I understand the HIPAA Disclosure Authorization(s) above may be revoked in writing at any time; however, the revocation will not affect disclosures of information previously authorized. I understand this authorization is valid while I continue to receive services from any BJC Medical Group provider.

______________________ Signature of Patient/Personal Representative

______________________ Relationship to Patient

______________________ Date