# NASHVILLE KNEE AND SHOULDER CENTER, PLLC

NASHVILLE KNEE & SHOULDER

## Patient Information

Patient Name: _____ Responsible Party: _____

Address: _____

Zip Code: _____ City, State: _____

Home #: _____ Marital Status: _____

Work #: _____ Date of Birth: _____

Cell #: _____ Social Security #: _____

Email: _____

Sex: _____ Employer: _____

Emergency Contact: _____ Phone: _____

## Responsible Party Information (i.e. if insurance is not in your name)

Name: _____ Sex: _____

Social Security #: _____ Date of Birth: _____

Address: _____

Zip Code: _____ City, State: , _____

Home #: _____ Employer: _____

Work #: _____ Cell #: _____

## Primary Insurance

Insurance Company: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber Id #: _____ Group #: _____

Group Name: _____ Insurance Phone #: _____

Copay: _____ Effective Date: _____

## Secondary Insurances

Insurance Company: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber Id #: _____ Group #: _____

Group Name: _____ Insurance Phone #: _____

Copay: _____ Effective Date: _____

# NASHVILLE KNEE AND SHOULDER CENTER, PLLC

NASHVILLE KNEE & SHOULDER

## Medical History

Name: _____ Age: _____ Height: _____ Weight: _____

Who referred you? _____

Name/Address of referring physician: _____

Family Physician: _____

Which part of your body is bothering you? _____

(Please select one if applicable) Right side: ___ Left side: ___ Both sides: ___

Please describe your problem: _____

How long ago did you first notice your problem? _____

Occupation: _____ Did your injury occur on the job? _____

Is this a sports related injury? _____ If yes, what sport? _____

Do you have any of the following medical conditions? (Please check all that apply)

| | | |
|---|---|---|
| ___ Glaucoma | ___ Stomach Problems (Ulcers) | ___ Bleeding |
| ___ Seizures | ___ Liver Disease | ___ Diabetes |
| ___ Lung Disease | ___ Prostate/Urinary Problems | ___ Hypertension |
| ___ Asthma | ___ Kidney Stones | ___ Cancer |
| ___ Heart Disease | ___ Blood Clots | ___ Depression |

Have you ever had, or been diagnosed with MRSA? _____

Other Conditions: _____

Please list all surgical procedures: _____

List all medications you are presently taking: _____

Are you allergic to any medications? _____

If yes, please list the medications: _____

Tobacco Use: _____ Alcohol Use: _____ Drug Use: _____

Do any diseases run in your family? Diabetes: ___ Heart Disease:___ Cancer: ___

Other: _____

# NASHVILLE KNEE AND SHOULDER CENTER, PLLC

## Accident/Injury Information

Please describe in detail HOW, WHEN, and WHERE your problem began:

_____

Did you have a specific injury? _____

What was the exact date of injury? _____

Have you had treatment for this injury/problem? _____

If yes, please describe treatment: _____

Have x-rays been taken since the injury? _____

Have you had similar problems in the past? _____

If yes, please explain: _____

SUBMIT