

**University Orthopedic and Sports Medicine Clinic**

Erik J. Bruce, M.D.

New Patient

Update

Work Related Injury

**Patient Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)

Parent or Guardian Name (if applicable): \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alt. Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status:  M  S  D  W

Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Insurance Information**

Primary Insurance Carrier: \_\_\_\_\_ Type:  HMO  PPO  POS  Other

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Holders Name(if different from patient): \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer: \_\_\_\_\_

Relationship to Patient:  Spouse  Parent  Other: \_\_\_\_\_

I hereby assign my insurance benefits to be paid directly to University Orthopaedic and Sports Medicine Clinic and Ryan K Bergeson, MD, realizing that I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

\_\_\_\_\_  
Patient or Guardian's Signature

\_\_\_\_\_  
Date

**Medicare Authorization:** I authorize any holder of medical or other information about me to release, to the Social Security Administration and Health Care Financing Administration of the intermediaries or carrier, any information needed for this or any related Medicare claim. I permit a copy, of this authorization, to be used in place of the original and request payment of the medical insurance benefits to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I further understand that I will assume full responsibility for any Medical costs not covered by Medicare.

\_\_\_\_\_  
Patient or Guardian's Signature

\_\_\_\_\_  
Date

# Acknowledgement of Notice of Privacy Practices

I have been given the opportunity to review and/or receive a copy of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Account#: \_\_\_\_\_

Please list the names of individuals we can talk to about your medical care. (ex. spouse, children, parents, siblings, etc.)

Name

Relationship

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Erik J. Bruce, MD**

**Notice of Privacy Practices  
SUMMARY**

**The attached notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This document is intended to serve as a summary of our privacy practices only.**

The privacy notice applies to any of the providers that may provide care to you at University Orthopaedic and Sports Medicine Clinic. 301 Seton Parkway, Suite 305, Round Rock, TX 78665.

**Uses and Disclosures**

*Permitted without Authorization:*

- Treatment, Payment and Operations
- Public Health, Abuse or Neglect, and Health Oversight
- Legal Proceedings and Law Enforcement
- Workers' Compensation
- Inmates
- Military, Nat'l Security & Intelligence Activities, Protection of the President
- Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
- Certain uses & disclosures including appointment reminders, treatment alternatives, and other health-related benefits

*Require Authorization:*

- Disclosures to Friends or Family
- Any other requested disclosure

**Your Rights under Federal Privacy Regulations**

- Request restrictions or limit disclosures for treatment, payment or operations.
- Receive confidential communications by alternative means
- Inspection and Copies of Protected Health Information
- Request amendment to your medical record
- Accounting of Certain Disclosures
- Right to a Copy of Privacy Notice

**University Orthopaedic and Sports Medicine Clinic's**

Protect the privacy of your medical information and to abide by the terms of the notice of privacy practices in effect.

- Contacts for questions, complaints, amendments and accounting:

Region VI, Office for Civil Rights

U.S. Department of Health and Human Services

1301 Young Street, Suite 1169  
Dallas, TX 75202

University Orthopaedic Sports Medicine Clinic  
Lea Ann Lavender (Office Manager)  
301 Seton Parkway, #305, Round Rock, TX 78665  
512-388-2663

**Effective Date: April 3, 2010**

University Orthopaedic and Sports Medicine Clinic  
Erik J. Bruce, M.D.

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
 Male  Female

**How were you referred to Our Office?** \_\_\_\_\_

**Chief Complaint/ History of Present Illness:**

Why are you seeing the doctor today? \_\_\_\_\_  
Are you  Right or  Left Hand Dominant?

**Describe your symptoms** (check all that apply):

**Location:**  Right or  Left  
 Shoulder  Arm  Wrist  Hand  Hip  Leg  Knee  Foot  Other \_\_\_\_\_  
 Front  Back  Inside  Outside  Top/Upper  Bottom/Lower

**Quality of Pain:**  Sharp  Dull  Stabbing  Throbbing  Aching  Burning  Tingling  
**Rate of Discomfort:** (circle one) None - 0 1 2 3 4 5 6 7 8 9 10 –Severe

**Duration of Pain:**  Constant  Intermittent (off and on)  
 Stiffness When? \_\_\_\_\_  Numbness Where? \_\_\_\_\_  
 Swelling When? \_\_\_\_\_  Locking/Catching When? \_\_\_\_\_  
 Popping When? \_\_\_\_\_  Weakness When? \_\_\_\_\_

**How long have you had this problem?** \_\_\_\_\_ day(s) \_\_\_\_\_ week(s) \_\_\_\_\_ month(s) \_\_\_\_\_ year(s)

**How do your symptoms occur?**  Walking  Running  Stairs  At work  After work  At night  In morning  
 At night  Lifting  Rising from Chair  During exercise  After exercise  Other \_\_\_\_\_

**What makes your symptoms better?**  Rest  Therapy  Heat  Cold  Brace/Bandage  Exercise  
 Medication What medication? \_\_\_\_\_

**Have you had any other treatment or surgery for this problem?**  Yes  No  
If yes, please describe: \_\_\_\_\_

Who was your doctor? \_\_\_\_\_ When/ Where? \_\_\_\_\_  
Have you had any  X-Rays  MRI's  CT scans or  Other Diagnostic Studies \_\_\_\_\_ Where? \_\_\_\_\_

**Have you missed any work because of this problem?**  Yes  No If yes, please specify dates: \_\_\_\_\_

**Accident Injury Details:**

Describe how your accident/ injury occurred \_\_\_\_\_

The accident injury location was: \_\_\_\_\_  
Date of accident/ injury: \_\_\_\_\_

Were you on the job or is it related to work?  Yes  No  
If yes, your employers name: \_\_\_\_\_ Phone: \_\_\_\_\_  
If yes, did you report it to your employer?  Yes  No

If your injury was due to an auto accident: Were you  driver  passenger  pedestrian  
Your auto insurance company: \_\_\_\_\_

Did your accident occur on someone else's property?  Yes  No

The forgoing is true and correct to the best of my knowledge.

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

**Social History:**

Employment Status: Self Employed Retired Student (Full Time or Part Time?)  
Employed (Full Time or Part Time?) Occupation \_\_\_\_\_  
Single Married Divorced Separated Widowed  
Children: Yes No If yes, indicate number \_\_\_\_\_

Do you smoke or use tobacco products? Yes No Past  
How long ago? \_\_\_\_\_ If yes, amount per day \_\_\_\_\_

Do you drink alcohol? Yes No Number per week \_\_\_\_\_  
Has anyone ever told you to cut down on your drinking? Yes No  
Do you use drugs for reasons other than medical? Yes No If yes, please list: \_\_\_\_\_  
Do you now or have you ever used IV drugs? Yes No Past- How long ago? \_\_\_\_\_  
Do you exercise regularly? Yes No If yes, what type? \_\_\_\_\_  
What hobbies or sports do you participate in? \_\_\_\_\_

**Family History:**

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				

**Past Medical History:**

Drug Allergies: Yes No If yes, to what? \_\_\_\_\_  
Type of reaction(s): \_\_\_\_\_

**Natural or Alternative Therapies:** (chiropractic, magnets, massage, over-the-counter preparations, vitamins, herbal supplement(s): \_\_\_\_\_

**Surgeries/Hospitalizations:**

Description of surgery/hospitalization	Date	Results/Complications

**Medical Conditions/ Illnesses:** Do you now or have you ever had: (Click if "yes")

- Cancer      Diabetes      Stroke      Heart Problems      High Blood Pressure
- Cataracts      Epilepsy      Colitis      Nervous Breakdown      Stomach Ulcers
- Pneumonia      Jaundice      Anemia      Kidney Disease      History of Blood Clots
- Asthma      HIV/AIDS      Glaucoma      Bad Headaches      Problems with Anesthesia
- Tuberculosis      Psoriasis      Emphysema      Rheumatic Fever      Goiter      Leukemia

Other significant illness (please list): \_\_\_\_\_

The name of the physician providing your primary medical care &/or physician caring for illness(es) listed above: \_\_\_\_\_

The forgoing is true and correct to the best of my knowledge.

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

**Review of Systems:**

Date of last mammogram: \_\_\_\_\_ Date of last eye exam: \_\_\_\_\_ Date of last chest x-ray: \_\_\_\_\_

Date of last tuberculosis test: \_\_\_\_\_

Date of last bone density study: \_\_\_\_\_ Results: Normal Osteopenic Osteoporotic

As you review the following list, please check whether or not any of the following conditions have affected you.

<b>Constitutional</b>	<b>Y/N</b>	<b>Gastrointestinal</b>	<b>Y/N</b>	<b>Integumentary(skin &amp;/or breast)</b>	<b>Y/N</b>
Recent weight gain: amount	<input type="checkbox"/> <input type="checkbox"/>	Nausea	<input type="checkbox"/> <input type="checkbox"/>	Easy bruising	<input type="checkbox"/> <input type="checkbox"/>
Recent weight loss: amount	<input type="checkbox"/> <input type="checkbox"/>	Vomiting	<input type="checkbox"/> <input type="checkbox"/>	Redness	<input type="checkbox"/> <input type="checkbox"/>
Fatigue	<input type="checkbox"/> <input type="checkbox"/>	Stomach pain relieved by food or milk	<input type="checkbox"/> <input type="checkbox"/>	Rash	<input type="checkbox"/> <input type="checkbox"/>
Weakness	<input type="checkbox"/> <input type="checkbox"/>	Jaundice	<input type="checkbox"/> <input type="checkbox"/>	Hives	<input type="checkbox"/> <input type="checkbox"/>
Fever	<input type="checkbox"/> <input type="checkbox"/>	Increasing constipation	<input type="checkbox"/> <input type="checkbox"/>	Sun sensitive (sun allergy)	<input type="checkbox"/> <input type="checkbox"/>
<b>Eyes</b>	<b>Y/N</b>	Persistent diarrhea	<input type="checkbox"/> <input type="checkbox"/>	Tightness	<input type="checkbox"/> <input type="checkbox"/>
Pain	<input type="checkbox"/> <input type="checkbox"/>	Blood in stools	<input type="checkbox"/> <input type="checkbox"/>	Nodules/bumps	<input type="checkbox"/> <input type="checkbox"/>
Redness	<input type="checkbox"/> <input type="checkbox"/>	Heartburn	<input type="checkbox"/> <input type="checkbox"/>	Hair loss	<input type="checkbox"/> <input type="checkbox"/>
Loss of vision	<input type="checkbox"/> <input type="checkbox"/>	<b>Genitourinary</b>	<b>Y/N</b>	Color changes hands &/or feet	<input type="checkbox"/> <input type="checkbox"/>
Double or blurred vision	<input type="checkbox"/> <input type="checkbox"/>	Difficult urination	<input type="checkbox"/> <input type="checkbox"/>	in cold	
Dryness	<input type="checkbox"/> <input type="checkbox"/>	Pain or burning on urination	<input type="checkbox"/> <input type="checkbox"/>	<b>Neurological System</b>	<b>Y/N</b>
<b>Ears-Nose-Mouth-Throat</b>	<b>Y/N</b>	Blood in urine	<input type="checkbox"/> <input type="checkbox"/>	Headaches	<input type="checkbox"/> <input type="checkbox"/>
Loss of hearing	<input type="checkbox"/> <input type="checkbox"/>	Cloudy, "smoky" urine	<input type="checkbox"/> <input type="checkbox"/>	Dizziness	<input type="checkbox"/> <input type="checkbox"/>
Nosebleeds	<input type="checkbox"/> <input type="checkbox"/>	<b>For Women Only:</b>	<b>Y/N</b>	Fainting	<input type="checkbox"/> <input type="checkbox"/>
Sore tongue	<input type="checkbox"/> <input type="checkbox"/>	Periods regular	<input type="checkbox"/> <input type="checkbox"/>	Muscle spasm	<input type="checkbox"/> <input type="checkbox"/>
Bleeding gums	<input type="checkbox"/> <input type="checkbox"/>	Date of last period ____/____/____		Loss of consciousness	<input type="checkbox"/> <input type="checkbox"/>
Sores in mouth	<input type="checkbox"/> <input type="checkbox"/>	Number of pregnancies _____		Sensitivity of pain in hands	<input type="checkbox"/> <input type="checkbox"/>
Dryness of mouth	<input type="checkbox"/> <input type="checkbox"/>	Number of miscarriages _____		&/or feet	
Hoarseness	<input type="checkbox"/> <input type="checkbox"/>	<b>Musculoskeletal</b>	<b>Y/N</b>	Memory loss	<input type="checkbox"/> <input type="checkbox"/>
Difficulty in swallowing	<input type="checkbox"/> <input type="checkbox"/>	Morning stiffness	<input type="checkbox"/> <input type="checkbox"/>	Night sweats	<input type="checkbox"/> <input type="checkbox"/>
<b>Cardiovascular</b>	<b>Y/N</b>	Lasting how long?		<b>Psychiatric</b>	<b>Y/N</b>
Pain in chest	<input type="checkbox"/> <input type="checkbox"/>	____minutes ____hours		Depression	<input type="checkbox"/> <input type="checkbox"/>
Irregular heart beat	<input type="checkbox"/> <input type="checkbox"/>	Joint pain	<input type="checkbox"/> <input type="checkbox"/>	Difficulty falling asleep	<input type="checkbox"/> <input type="checkbox"/>
Sudden changes in heart beat	<input type="checkbox"/> <input type="checkbox"/>	Muscle weakness	<input type="checkbox"/> <input type="checkbox"/>	Difficulty staying asleep	<input type="checkbox"/> <input type="checkbox"/>
Muscle tenderness	<input type="checkbox"/> <input type="checkbox"/>	Joint swelling	<input type="checkbox"/> <input type="checkbox"/>	<b>Endocrine</b>	<b>Y/N</b>
High blood pressure	<input type="checkbox"/> <input type="checkbox"/>	List joint affected in the last 6 mos.		Excessive thirst	<input type="checkbox"/> <input type="checkbox"/>
Heart murmurs	<input type="checkbox"/> <input type="checkbox"/>	_____		<b>Hematologic/Lymphatic</b>	<b>Y/N</b>
<b>Respiratory</b>	<b>Y/N</b>	_____		Swollen glands	<input type="checkbox"/> <input type="checkbox"/>
Shortness of breath	<input type="checkbox"/> <input type="checkbox"/>	_____		Tender glands	<input type="checkbox"/> <input type="checkbox"/>
Difficulty in breathing at night	<input type="checkbox"/> <input type="checkbox"/>	_____		Anemia	<input type="checkbox"/> <input type="checkbox"/>
Swollen legs or feet	<input type="checkbox"/> <input type="checkbox"/>	_____		Bleeding tendency	<input type="checkbox"/> <input type="checkbox"/>
Cough	<input type="checkbox"/> <input type="checkbox"/>	_____		Transfusion/ when _____	<input type="checkbox"/> <input type="checkbox"/>
Coughing of blood	<input type="checkbox"/> <input type="checkbox"/>			<b>Allergic/Immunologic</b>	<b>Y/N</b>
Wheezing (asthma)	<input type="checkbox"/> <input type="checkbox"/>			Frequent sneezing	<input type="checkbox"/> <input type="checkbox"/>
				Increased susceptibility to	<input type="checkbox"/> <input type="checkbox"/>
				Infection	

Signature of Individual Completing Form:

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name \_\_\_\_\_

If other than patient, your relationship to patient \_\_\_\_\_

Reviewed by: _____
Date: _____



