LOCKNANE
ATHLETIC MEDICINE

Timothy D. Locknane MD

PATIENT REGISTRATION

Patient Name:____ **M** or **F**
Last First Middle Initial Gender

Birth Date: _____ / _____ / _______ **Age:** ____ **SS#:** ____________________________

Home Address: ____
Street Apt. #
____
City State Zip

Home Phone: ( ) _______________ **Work Phone**: ( ) _______________

Cell Phone: ( ) _______________ **E-mail:**_____________________________

Marital Status: ( ) Single ( )Married ( ) Other_____________________________

Primary Care Physician: ____

Primary Care Physician Phone#:____

Referred to LAM by: _________________________________(Dr. / Patient / Friend)

BILLING INFORMATION

PRIMARY INSURANCE
Ins. Co. Name: _______________________
Subscriber Name: _____________________
Date of Birth: _________________________
Group #: _____________________________
ID#:_________________________________
Employer: ____________________________

SECONDARY INSURANCE
Ins. Co. Name:_______________________
Subscriber Name:_____________________
Date of Birth:__________________________
Group #: _____________________________
ID#:_________________________________
Employer:_____________________________

Does your insurance carrier require a referral? ( ) Yes ( ) No

I request that payment of authorized Medicare or insurance benefits be made to my physician on my behalf for any services provided to me by Timothy D. Locknane MD and Locknane Athletic Medicine. I authorize any holder of medical information about me to release to HCFA and its agents or to my insurance any information needed to determine these benefits. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment, and I accept financial responsibility for non-covered services.

_______________________________________ _____________________
Signature Date

18518 Bothell Way NE, Suite C Bothell, WA 98011 ***Office*** *– 425.368.4242* ***Fax*** *– 425.368.4243*
www.movewithlife.com

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NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Locknane Athletic Medicine.

By my signature below I acknowledge and receipt of the Notice of the Privacy Practices

Patient or legally authorized individual signature | Date | Time

Printed name if signed on behalf of the patient | Relationship

Staff Notes:

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HEALTH HISTORY FORM

Please take a few minutes to complete this form. By doing so you will help Dr. Locknane provide the best medical care possible. Thank You.

Please be brief and only list pertinent information. **DATE:**______________________

Patient Name: ______________________________________ D.O.B.: ____________________

TO BE FILLED OUT BY PATIENT: **Height:**___________ **Weight:** __________

REVIEW OF SYSTEMS

GENERAL:	Fever	Weight Loss	Weight Gain	Fatigue	
EYES:	Glasses	Contacts	Trauma	Blurring	Double Vision
HEART:	Chest Pain	Leg Swelling	Irregular Heartbeat	Palpitations	
RESPIRATORY:	Sputum	Cough	Shortness Breath		
INTESTINAL:	Diarrhea	Constipation	Pain	Jaundice	Blood in Stool
URINARY:	Hesitancy	Pain	Incontinence	Kidney Stones	Bladder Infections
SKIN:	Lesions	Rash	Scars	Masses	Eczema
HEMATOLOGIC:	Anemia	Blood Clots			
NEUROLOGIC:	Numbness	Balance Problems	Seizures/Weakness	Memory Loss	

YOUR HISTORY:
- ☐ Cancer
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Blood Clots
- ☐ Other ____________________

FAMILY HISTORY:
- ☐ Cancer
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Blood Clots
- ☐ Other ______________________

SURGERY HISTORY:

____

____

____

SOCIAL HISTORY: ☐ Single ☐ Married ☐ Other ______________________

I consider myself: ☐ Appropriate Wt. ☐ Overweight ☐ Underweight

Related to this, I am ____

Tobacco? ☐ Yes ☐ No How much? ____________________

If so, when do you plan to quit? ______________________________________

Alcohol? ☐ Yes ☐ No How much? ____________________

Does its use negatively affect your relationships or vocation? ☐ Yes ☐ No

Exercise Level? ☐ None ☐ 1-2 times/wk ☐ 3-4 times/wk ☐ 5+ times/wk

Activities: ____

MEDICATIONS (Please list medications, doses and frequency)

1. ________________________________ 2. ________________________________

3. ________________________________ 4. ________________________________

DRUG ALLERGIES:__________________________________ **None known** __________________

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ORTHOPEDIC HISTORY FORM

Please be brief and only list pertinent information. **DATE:**______________________

Patient Name: ____________________________________ D.O.B.: ____________________

Location of Problem: ______________________ Circle: **R** or **L** Onset Date: ______________________

If injury, describe briefly: ____

____

____

Any previous surgery or injury at problem site? ______________________ Approx. Date: ____________

INJURY/SYMPTOMS			
Did you feel/hear a pop or tear?	YES	NO	UNSURE
Did your joint pop out?	YES	NO	UNSURE
Did you have weakness?	YES	NO	UNSURE
Did you continue activity?	YES	NO	UNSURE
Does it feel loose or unstable?	YES	NO	UNSURE

PRIOR TREATMENT			
Did you see a physician?	YES	NO	MD Name:
Were X-rays taken?	YES	NO	_______________
Medication Prescribed?	YES	NO	Rx Name:
Physical Therapy?	YES	NO	_______________
Injection(s)?	YES	NO	

Other Treatment / Procedures: ____

____

DESCRIPTION OF PAIN / DISCOMFORT						
Location:	Front	Back	Top	Side	Inside	Outside
Severity:	Scale (1=Low, 10=High) __________________					
Frequency:	Occasional	Intermittent	Constant			
Type:	Sharp	Aching	Throbbing	Burning		
Aggravated by:	Lifting	Reaching	Walking	Running	Twisting	Pushing
	Squatting	Kneeling	Stairs	Overhead Use	Throwing	
NIGHT PAIN	YES	NO				

PERCENT OF REGULAR USE ________________

Are you experiencing any of the following?

NUMBNESS TINGLING SWELLING STIFFNESS GRINDING GIVING WAY LOCKING NIGHT PAIN

PRESENT OVERALL FUNCTION

PERCENT OF REGULAR USE ________________

How far can you walk? _________________________ blocks _____________________________ miles

Can you climb stairs? YES NO ______ with assistance ______ without assistance

What is your present occupation? ____

Are you currently working? YES NO (if no) date last worked? ______________________

Other notes or comments:

____

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