



Orthopaedic Specialists, P.A.

PATIENT INFORMATION

Name: _____ Birthdate: _____ Age _____
Last First MI Month/Day/Yr.

Sex: M F Marital Status: Single Married Widowed Divorced

Home Address: _____
Street City State Zip

Home Phone: () _____ Work Phone: () _____ Fax: () _____

Work Address: _____
Street City State Zip

Social Security Number: _____ E-mail address: _____

Employer: _____ Occupation: _____

Spouse/Guardian Name: _____ Employer: _____

Phone: () _____ SSN: _____ Date of Birth: _____

IF PATIENT IS A MINOR PLEASE COMPLETE THE FOLLOWING:

Mother's Name: _____ Father's Name: _____

Mother's Employer: _____ Father's Employer: _____

Work Phone Number: () _____ Work Phone Number: () _____

Address if Different Than Above (Please indicate which parent)

_____ Street City State Zip

Home Phone Number if Different Than Above (Please indicate which parent) () () _____

Family Physician: _____ Referring Physician: _____

Who should we contact in the event of an emergency? Name: _____

Relationship: _____ Phone: _____

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits for myself directly to Orthopaedic Specialists, P.A. for professional services rendered.

Sign _____ Date _____

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process this claim.

Sign _____ Date _____

BILLING INFORMATION:

PRIMARY:

Name of Co: _____

Address: _____

ID# _____ Group # _____

Subscriber: _____

Relationship to Patient: _____

SECONDARY:

Name of Co: _____

Address: _____

ID# _____ Group # _____

Subscriber: _____

Relationship to Patient: _____

MEDICAL INFORMATION

1. Please describe your present problem in detail (i.e., right index finger, middle toe on left foot, etc.)

2. When did the symptoms start?

3. a. Is your problem the result of an accident? Y N

b. If yes, was this accident an auto accident? _____

(If injury is the result of an auto accident, please make sure you notify receptionist and fill out the blue accident form.)

c. Was this accident work related? _____

(If this injury was work related, please make sure you notify receptionist and fill out yellow workman's compensation form.)

d. If your problem is the result of some type of accident not mentioned above, please give the date and describe briefly what happened. Date of accident: / / Description: _____

4. Have you ever had a similar problem? _____ When? _____

- a. Did you have treatment for this problem? _____
- b. Other doctors who treated you for this. _____
- c. What was the outcome of this treatment? _____

5. Please list any medications and the dosage of the medications you are currently taking. The dose may be found on the prescription bottle.

_____	_____
_____	_____
_____	_____
_____	_____

6. Are you allergic to any: Food? _____ Medication? _____ If yes, please list below.

7. Have you lost or gained more than ten pounds in the past year? Yes No

If yes, how much? _____ Was it intentional: Yes No

8. Social Habits (please circle)

Do you currently smoke? Y N

Have you smoked previously Y N
 _____ packs/day for _____ years

Do you drink alcohol? Y N

Have you drank alcohol in the past? Y N
 How much per day/week _____

Have you ever used recreational or intravenous drugs? Y N

9. Do you have osteoporosis or have you ever had a Bone Density Test? Y N

10. Have you ever been tested for osteoporosis in the past? Y N

By Whom? _____

11. Family History (mother, father, sister, brother only) – Please circle.

Diabetes
 Kidney Disease
 Heart Disease
 Other _____

Stroke
 High Blood Pressure
 Blood Clots

Cancer
 Neurological
 Bleeding Problems

12. Are you right or left handed? _____

13. Height _____ Weight _____

PLEASE CIRCLE "YES" OR "NO", LEAVE BLANK IF UNCERTAIN

Do you or have you experienced the following:

Do you have now or have you had within the past 18 months?

- Y N Alcohol Abuse
- Y N Artificial Bones/Joints
- Y N Artificial Valves
- Y N Asthma/Emphysema
- Y N Bleeding Problems
- Y N Blood Transfusion
- Y N Cancer
- Y N Colitis (Ulcerative Colitis/
Crohn's Disease)
- Y N Heart Defect/Murmur
- Y N Diabetes
- Y N Drug Abuse
- Y N Epilepsy
- Y N Esophagitis
- Y N Heart Disease
- Y N Hemophilia
- Y N Hepatitis/Jaundice
- Y N High Blood Pressure
- Y N Kidney Problems/Stones
- Y N Liver Problems
- Y N Mitral Valve Prolapse
- Y N Pacemaker
- Y N Stroke
- Y N Thyroid Problems
- Y N Stomach Ulcers

- Y N Depression/Anxiety (circle)
- Y N Paralysis
- Y N Backaches
- Y N Enlarged Veins
- Y N Blood Clots
- Y N Gallbladder Disease
- Y N Joint pain or stiffness
- Y N Leg cramps with walking
- Y N Leg cramps at night
- Y N Muscle cramps or spasms
- Y N Poor coordination
- Y N Swelling of hands/feet/ankle
- Y N Swollen joints
- Y N Easy bleeding or bruising
- Y N Latex allergies
- Y N Colon trouble
- Y N Colon Polyps
- Y N Tuberculosis
- Y N Diverticulitis

Do you, or have you had in the past, any other medical condition that the doctor should be made aware?

Yes

No

If yes, please describe _____

Patient Signature

Date