Orthopedic Surgery

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New Patient Paperwork

Today's Date: _____

Name: _____ DOB: _____ Age: _____

Address: _____ Phone #: _____

Secondary Phone #: _____ City: _____

State: _____ Zip Code: _____ SS#: _____ Sex: _____

Email: _____ Alt Phone #: _____

Marital Status: ☐Single ☐Married ☐Divorce ☐Separated ☐Widowed

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone #: _____

Primary Care Physician: _____ Phone #: _____

Cardiologist: _____ Phone #: _____

Referred By: _____ Phone #: _____

Relationship of Guarantor to Patient: ☐Self ☐Spouse ☐Parent ☐Other _____

Name: _____ DOB: _____

Primary Ins: _____ Policy ID #: _____

Secondary Ins: _____ Policy ID #: _____

Pharmacy: _____ Phone #: _____

Occupation: _____ Phone #: _____

Print Name: _____ Signature: _____ Date: _____

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Patient Name: _____ Date of Birth: _____

Phone #: _____ Height: _____ Weight: _____

Are you: ☐ Right Handed or ☐ Left Handed

Chief Complaint: _____

Was there an injury: ☐ Yes ☐ No If yes, how did you get injured? Describe below:

_____

Date of injury: _____ How long have you had the problem: _____

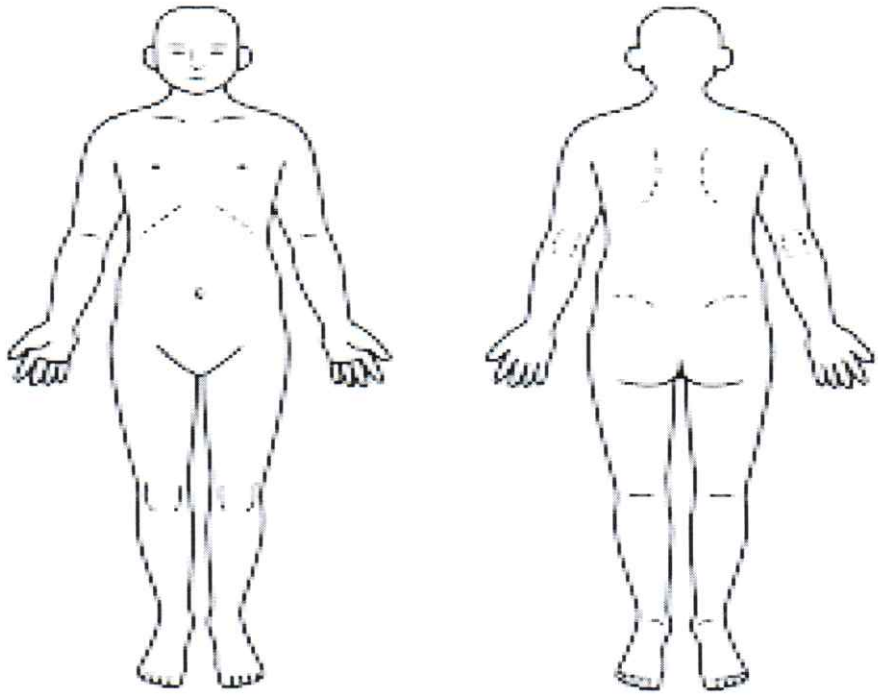
Is this work related: ☐ Yes ☐ No Was it reported: ☐ Yes ☐ No

Where is the pain/problem: _____

Does it travel to other areas: : ☐ Yes ☐ No If yes, where: _____

Rate your pain on a scaled of 1-10, 10 being the worst pain: _____

Draw a circle where you are having the problem:



Diplomate, American Board of Orthopedic Surgeons

Sports Medicine Arthroscopic Surgery Regenerative Medicine General Orthopedics

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Quality of pain: ☐ Dull ☐ Throbbing ☐ Sharp

If there is a lump, is it: ☐ Warm ☐ Tender ☐ Red

Associated Symptoms: ☐ Popping ☐ Clicking ☐ Swelling ☐ Grinding ☐ Other: _____

What makes it better: _____ What makes it worse: _____

Activities you can no longer perform: _____

Hobbies/ Sports: _____

Have you seen any other physicians for treatment regarding this condition: ☐ Yes ☐ No

If yes, what is the physicians name: _____

Which of the following treatments have you had for this problem:

☐ Medications What medications: _____ Did it help: ☐ Yes ☐ No

☐ Physical Therapy How long: _____ Did it help: ☐ Yes ☐ No

☐ Injections How when & how many: _____ Did it help: ☐ Yes ☐ No

☐ Braces ☐ Crutches ☐ Other: _____

What type(s) of tests have you had? ☐ None

☐ MRI Date(s): _____ Body Part: _____ Where: _____

☐ Xray Date(s): _____ Body Part: _____ Where: _____

☐ Ultrasound Date(s): _____ Body Part: _____ Where: _____

☐ EMG Date(s): _____ Body Part: _____ Where: _____

☐ Bone Density Date(s): _____ Body Part: _____ Where: _____

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Medical History: ☐ NO PAST MEDICAL HISTORY

☐ AIDS or HIV	☐ Chronic Pain (CRPS)	☐ Neuropathy
☐ Anemia	☐ COPD	☐ Peripheral Vascular Disease
☐ Anxiety	☐ Deep Venous Thrombosis (DVT)	☐ Polio
☐ Arthritis	☐ Depression	☐ Pulmonary Embolism
☐ Asthma	☐ Diabetes Type: _____	☐ Rheumatoid Arthritis
		☐ Sleep Apnea
☐ Auto-Immune Disorder	☐ Epilepsy/ Seizures	☐ Stroke
☐ Back Trouble	☐ Fibromyalgia	☐ Thyroid Disease
☐ Blood Transfusions	☐ Gasto Esophageal Reflux	☐ Tuberculosis
☐ Bronchitis	☐ Gout	☐ Ulcer
☐ Cancer	☐ Heart Disease	☐ Valley Fever
Where: _____	☐ Hepatitis A/B/C	☐ Venereal Disease
Type of Treatment: _____	☐ High Blood Pressure	☐ Other (Please List)
_____	☐ Kidney Disease	
☐ Chemo ☐ Radiation	☐ Lupus	
☐ Surgery	☐ Lyme Disease	
	☐ Mitral Valve Prolapse	

Surgical History: ☐ NO PAST SURGERY

Type of Surgery	Date	Physician/Location

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Have you been hospitalized: ☐ Yes ☐ No

If so, date and reason of hospitalization: _____

_____

Medications: Include non-prescribed and herbal supplements

☐ NOT TAKING MEDICATION

Name	Dosage	Frequency

Allergic to any medications: ☐ NO KNOWN DRUG ALLERGIES

☐ Latex ☐ Tape ☐ Penicillin ☐ Contrast Dye ☐ Other:

List medication and reaction:

_____

_____

Family History: ☐ Non-Contributary

	Age	Condition/Disease	If diseased, cause of death
Father			
Mother			
Brother			
Sister			
Child			
Other:			

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Any other relevant medical issues or concerns:

_____
_____
_____
_____
_____

To the best of my knowledge, the questions of this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical history. I authorize the health care staff to perform the necessary services I may need.

Print Name: _____ Signature: _____

Initial each line item

_____ I consent to treatment necessary for the above patient.

_____ I authorize the release the release of all medical records to the referring physician.

_____ I authorize the release of my medical records, if necessary.

_____ I authorize that payment is due at the time of service.

_____ I agree to pay all reasonable payment to be made directly to Advanced Orthopedic Surgery and Sports Medicine.

_____ I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Print Name: _____ Signature: _____

Date: _____