Medical Records

Date ________________

PATIENT

Patient Name: ______________________ Age: ______ Sex: ______ Birthdate: ______________

Patient SSN # ________________ Phone # - Home: ____________ Work: ____________ Cell: ____________

Home Address: ______________________________ Email Address: ______________________

City ______________________ State ______________ Zip ____________

Who is responsible for the Bill? ❑ Patient ❑ Spouse ❑ Father ❑ Mother

Name of person responsible (if not patient) ______________________________

In case of emergency notify: ______________________________ Telephone ________________

Family's Cell Phones (Name and Number) ______________________________

SPOUSE

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Spouse's Name ______________________________ Spouse's SSN # ______________________

Spouse's Employer ______________________________

EMPLOYER

Employer of Patient or Responsible Party ______________________________

Employer Address ______________________________

City ______________________ State ______________ Zip ____________

Employer Phone ______________________________

CURRENT MEDICAL PROBLEM

Is your current medical problem the result of an Accident? ❑ Yes ❑ No

If an Accident, were you injured at ❑ Work ❑ School ❑ Auto ❑ Home ❑ Other

Date of Injury: ______________________ If not an Accident, date which symptoms began: ______________

PRIMARY INSURANCE

My primary insurance is: ❑ Private Insurance ❑ Workers Comp ❑ Medicare ❑ School Insurance ❑ None

Insurance Co. or Workers Comp Carrier Name: ______________________________

Name of insured as it appers on Insurance ID card: ______________________________ Effective Date: ______

Last First MI

Birthdate of insured: ______________________________

ID # or Contract #: ______________________ Group # or Medicare #: ______________________

Insurance Company Address ______________________________

City ______________________ State ______________ Zip ____________

SECONDARY INSURANCE

Secondary Insurance Company Name: ______________________________

Name of insured as it appers on card: ______________________________

Effective Date: ______________________________

Birthdate of insured: ______________________________

ID # or Contract #: ______________________ Group # or Medicare #: ______________________

Insurance Company Address ______________________________

City ______________________ State ______________ Zip ____________

I hereby request and authorize my insurance companies and/or Medicare to pay directly to OrthoSurgeons any proceeds payable under the terms of my policy and/or policies. I understand and agree any unpaid balance not covered by this policy is my responibility and will be paid in full by me. I also give my consent to OrthoSurgeons to release medical information to my insurance companies and/or Health Care Financing Administration.

Signed (If minor, reponsible party must sign) ______________________________ Date ____________

Medical Records

All Patients: Up-to-date information is essential for good medical care. Please supply the names of your doctors so that we can keep them informed.

Family Doctor / Internist or Pediatrician:

Doctor ______________________________

City ______________________________

Doctor ______________________________

Specialty ______________________________

City ______________________________

Doctor ______________________________

Speciality ______________________________

City ______________________________

Doctor ______________________________

Speciality ______________________________

City ______________________________

Athletes: We will keep your coach informed for you!

Coach ______________________________

Sport ______________________________

School ______________________________

City ______________________________

Who referred you to this office?

☐ Doctor (name) ______________________________

☐ Coach (name) ______________________________

☐ Worker's Comp Carrier (name) ______________

☐ HMO or PPO Book ______________________

Friend or Relative (name) ______________________

Other (name) ______________________________

Athletic Trainer (name) ______________________

By signing, I understand that I hereby authorize the release of information to the above named parties and also understand that OrthoSurgeons will continue to release information until we are notified to end correspondence to the above named parties.

Your signature ____

Patient Information: PLEASE COMPLETE ENTIRE FORM

NAME:_______________________ **TODAY'S DATE:**_____________ **AGE:**_____ **HEIGHT:**_____**ft**____**in WEIGHT:**____ **lbs.** **SEX: M / F**

Occupation and Employer: ______________________________________ **/** unemployed / disabled / student / work at home / retired

I stand: 0-2 hours / 2-8 hours / more than 8 hours per day **You are: right handed / left handed**

Marital Status: single / married / widowed / divorced / separated **Living arrangement:** alone / family / assisted living / nursing home

Do you drive a car? Y / N Do you participate in sports: Y / N Which ones?_____________ **Your Race:**__________________

Location of problem:______________________________ **When did problem begin?**____ days / weeks / months / years / not sure

Current Problem:

Description of problem: worker's comp / car wreck / other ____

Was there an injury? Y / N Have you had surgery on this area? Y / N (If so please list related surgery in the column below)

Description of pain: burning / dull / sharp **What relieves your pain?:** ____

Pain Intensity: 0 = no pain, 10 = horrible pain **1 2 3 4 5 6 7 8 9 10**

Who have you seen about this problem? No one / ER / another MD (name) ______________________________________

What did they do / recommend? (please circle all that apply) nothing / therapy / medicine / surgery / brace / injection / X-ray / MRI ___________

Past History: (Put a check if applicable under you or family)

Disease	You	Fam		You	Fam
Kidney disease			Gout		
Diabetes			Asthma		
High blood pressure			Osteoporosis		
Previous heart attack			Depression		
Previous stroke			Emphysema		
Coronary artery disease			Heart failure		
Cancer (list below)			Rheumatoid arthritis		
Peripheral artery disease			Atrial fibrillation		
Blood clot in leg or lung			Osteoarthritis		
Pacemaker			Hypothyroidism		
Stomach ulcers			HIV/AIDS		
Seizures			Hepatitis		

Surgery	You	Fam	Surgery (other)	Date
Tonsillectomy				
Appendectomy				
Hysterectomy				
Gallbladder removal				
Heart bypass or stents				
Heart valve				
C-section				
Hip replacement R / L				
Knee replacement R / L				
Knee scope R / L				
Shoulder scope R / L				
Fracture surgery				
Hernia repair				

Medicine List (include over-the-counter and dosages)

____

____

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Drug allergies: NONE / penicillin / sulfa / codeine / morphine / aspirin / NSAIDS / oxycodone / hydrocodone / iodine or

OTHER: ______________________________________

____

Are you currently pregnant? Y / N

Are you currently taking birth control? Y / N

Do you smoke? Y / N How much? _____ packs / day

Do you take a blood thinner? Y / N

Do you drink? Y / N How often? _____ times / week

Does your religious preference prohibit you from donating or receiving blood? Y / N

____

Review of Systems: Circle if symptom is present, ~~cross-out~~ if not present.

Constitutional: fever / chills / weight change / fatigue

Eyes: blurred vision / glasses / contacts / cataracts / blindness

ENT: ringing in ears / deafness / tooth decay / sinus problems / hard of hearing

CV: palpitations / short of breath / cold extremities / swelling of feet/legs

Resp: productive cough / wheezing / chronic cough

GI: diarrhea / constipation / heartburn / stomach pain

GU: burning urination / incontinence / kidney stones

Musculoskeletal: arthritis / fractures in past / weak extremities

Skin: rash / unhealed sores / itching / varicose veins

Neuro: numbness in hands / feet or tingling in hands / feet

Psych: depression / anxiety / insomnia / memory loss

Heme: bleeding tendency / easy bruising

Endo: excessive thirst / excessive urination

Immun: latex allergy / metal allergy / HIV / hepatitis C / iodine allergy

Other Symptoms:_____________________________ **Patient Signature:** ______________________________________