

PATIENT INFORMATION SHEET

Please Print

Today's Date _____

Are you here at the request of another physician? Yes No If yes, physician's name _____

Name of Family Physician (if different than above) _____

Patient's Name _____ SEX: M F DATE OF BIRTH ___/___/___

AGE _____ PATIENT'S SS# _____ - _____ - _____ MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____ EMAIL _____

Please check this box if you **do not** want to receive a patient experience survey from The Orthopaedic Institute via email.

HOME PH (_____) _____ WORK PH (_____) _____ CELL PH (_____) _____

Employer _____ Ph(_____) _____

Employer Address _____ Occupation _____

City _____ State _____ Zip _____

PRIMARY INSURANCE

Insurance Company Name _____ Policy/Group # _____

Guarantor (if other than patient) _____ Date of Birth ___/___/___ SS# _____ - _____ - _____

Guarantor's Phone# (_____) _____ Insurance Claim Address _____

City _____ State _____ Zip _____

SECONDARY INSURANCE

Insurance Company Name _____ Policy/Group # _____

Guarantor (if other than patient) _____ Date of Birth ___/___/___ SS# _____ - _____ - _____

Guarantor's Phone# (_____) _____ Insurance Claim Address _____

City _____ State _____ Zip _____

NAME OF PERSON FINANCIALLY RESPONSIBLE FOR THIS BILL _____

Relationship to Patient _____ Drivers License # _____

Date of Birth ___/___/___ SS# _____ - _____ - _____

Has any member of your immediate family been treated by our physician(s) before? Yes No

If Yes, name of family member _____

If student, name of school _____

MARITAL STATUS: Single Married Widowed Divorced Separated Spouse's Date of Birth ___/___/___

Spouse's Name _____ Spouse's SS# _____ - _____ - _____

Employer _____ Ph (_____) _____

Spouse's Insurance Company _____ Policy/Group # _____

Insurance Claims Address _____

City _____ State _____ Zip _____

NEAREST RELATIVE NOT LIVING WITH YOU _____

RELATIONSHIP TO YOU _____ PH (_____) _____

IF ON THE JOB INJURY (WORKERS' COMPENSATION), COMPLETE THE FOLLOWING:

Has notice of injury been filed by employer? Yes No Date of injury ___/___/___

Employer at time of injury _____ Ph (_____) _____

Employer Address _____

City _____ State _____ Zip _____

Work Comp Carrier _____ Ph (_____) _____

Address for Claims _____

City _____ State _____ Zip _____

Verified By _____ Date ___/___/___ Initial _____

PATIENT HISTORY

Patient Name _____ Age _____

Today's date _____ Hand dominance: Are you right-handed left-handed

What medical problem brought you to see the doctor today? Which body part is affected? What side?

Does the pain travel to other areas? Yes No Where? _____

What makes the symptoms better? _____

What makes the symptoms worse? _____

Date symptoms started _____ Problems caused by injury or accident? Yes No

Where did injury occur? _____

Details of accident _____

If open wound, date of last tetanus _____

Previous treatment for injury / illness stated above that you are being seen for today:

Emergency room: Yes No Where? _____

Doctor's office: Yes No Name of doctor _____

What treatment was prescribed for this problem? (Please check all that apply)

- EXERCISE CAST BRACE SPLINT SLING DIET REST ELEVATTON
CRUTCHES OTHER TREATMENT _____

Have X-Rays, MRI's, CT's or any other diagnostic test been performed for this injury? Yes No

If yes, which test was performed? _____

Previous problems of a similar nature _____

MEDICAL HISTORY/REVIEW OF SYSTEMS - Check the box that best describes your relationship to the listed health issues.

Also check the Family History box if an immediate family member is or has been affected (parents, siblings or children).

Please note, items left blank indicate a negative response.

			Family				Family	
<u>CONSTITUTIONAL</u>	Past	Present	History		<u>CARDIAC</u>	Past	Present	History
Fever		<input type="checkbox"/>			Palpitations/Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	
Chills		<input type="checkbox"/>			Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>			High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats		<input type="checkbox"/>			<u>GASTROINTESTINAL</u>			
<u>CENTRAL NERVOUS SYSTEM</u>					Nausea		<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Vomiting		<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Liver Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Blackouts	<input type="checkbox"/>	<input type="checkbox"/>			Intestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness		<input type="checkbox"/>			Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches		<input type="checkbox"/>			Gastroesophageal Reflux	<input type="checkbox"/>	<input type="checkbox"/>	
Visual Problems	<input type="checkbox"/>	<input type="checkbox"/>			Internal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>			Diarrhea		<input type="checkbox"/>	
<u>RESPIRATORY</u>					<u>URINARY</u>			
Cough		<input type="checkbox"/>			Pain / Difficulty Urinating	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of Breath		<input type="checkbox"/>			Kidney Problem	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			Prostate Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>			<u>INTEGUMENTARY</u>			
Sinus Infection	<input type="checkbox"/>	<input type="checkbox"/>			Rashes	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>			Burns	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>			<u>MUSCULOSKELETAL</u>			
<u>CARDIAC</u>					Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Other Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	

MEDICAL HISTORY/REVIEW OF SYSTEMS (Continued)

ENDOCRINE	Family			HEMATOLOGIC	Family		
	Past	Present	History		Past	Present	History
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Blood Clot/Phlebitis DTV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Bruising	<input type="checkbox"/>	<input type="checkbox"/>	

SURGICAL PROCEDURES: Have you had surgery in the past? Yes No

Indicate month and year in the blank next to any surgery you have had in the past.

- | | | | |
|----------------|---------------------|------------------------|-----------------------|
| _____Tonsils | _____Ovaries/Uterus | _____Heart | _____Small Intestine |
| _____Appendix | _____Thyroid | _____Colon | _____Hysterectomy |
| _____Stomach | _____Kidney | _____Breast | _____Vascular Surgery |
| _____Prostate | _____Back | _____Gall bladder | _____Splenectomy |
| _____C-section | _____Hernia Repair | _____Valve Replacement | |

Other _____

Any extremity surgery? If yes, please indicate which side by writing R or L next to the appropriate body part.

- _____Shoulder _____Elbow _____Wrist _____Hand _____Hip _____Knee _____Ankle _____Foot

What type of surgery did you have? _____

MEDICATIONS: Please list all current medications (including prescribed, herbal, and over-the-counter) and doses.

None

_____	_____
_____	_____
_____	_____

ALLERGIES:

Please check any allergies that apply to you:

- None Penicillin Sulfa Iodine Tetanus
Other _____

Please check any complications from your allergy:

- Nausea Hives Rash Swollen Throat Difficulty Breathing
Other _____

SOCIAL HISTORY:

Please check your response to - Do you live:

- Alone with Spouse with Family with Friend Other _____

Please indicate tobacco use: None

- Cigarettes: _____packs/day _____years of use Quit: _____ (please list year)
Other: _____frequency/day _____years of use Quit: _____ (please list year)

Please indicate alcohol use: none beer wine liquor

Do you drink? daily weekly occasionally

Are you currently working? Yes No If no, last date of work _____

Please check your work status:

- Work at home Work at the office Retired Student Disabled
Other _____

Type of work you perform: _____

Doctor's NOTES: _____

Physician's Signature _____ Date _____

SUPERCONFIDENTIAL INFORMATION

PAST MEDICAL HISTORY Please check any disease diagnosed at any time - items left blank indicate a negative response.

- alcoholism depression / anxiety other _____
- hepatitis controlled substance (Rx drugs) abuse Females Only -
- HIV / AIDS illegal drug use Pregnant? Yes No Uncertain

**CONSENT TO EXAMINATION AND TREATMENT
INSURANCE ASSIGNMENT AND RECORDS AUTHORIZATION**

I HEREBY CONSENT TO EXAMINATION AND TREATMENT AS DEEMED NECESSARY BY THE ORTHOPAEDIC INSTITUTE AND ITS PHYSICIANS. I HEREBY AUTHORIZE THE ORTHOPAEDIC INSTITUTE AND ITS PHYSICIANS TO FURNISH PATIENT HEALTH INFORMATION CONCERNING MY RELEVANT MEDICAL HISTORY (INCLUDING BUT NOT LIMITED TO THE SUPERCONFIDENTIAL INFORMATION LISTED ABOVE) TO ANY OF THE FOLLOWING: OTHER HEALTHCARE PROVIDERS INVOLVED IN MY CARE, INSURANCE CARRIERS, ATTORNEYS AND ADJUSTORS. I HEREBY ASSIGN TO THE ORTHOPAEDIC INSTITUTE AND ITS PHYSICIANS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

SIGNATURE _____ DATE ___/___/___

PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR) _____

**AUTHORIZATION FOR MEDICARE BILLING PURPOSES
LIFETIME FILE (MEDICARE PATIENTS ONLY)**

I hereby certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I hereby authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I hereby request that payment of authorized benefits be made on my behalf and hereby assign the benefits payable for physician services to the physician if he/she chooses to accept assignment.

SIGNATURE _____ DATE ___/___/___

PARENTAL RELEASE (IF PATIENT IS A MINOR)

I, _____ (legal guardian's name), hereby authorize The Orthopaedic Institute and its physicians to release any or all patient health information including superconfidential information regarding my child to the person(s) listed below (Example: A relative or someone other than a legal guardian may accompany your child on a future appointment).

SIGNATURE _____ DATE ___/___/___

Name _____ Relationship to patient _____ Ph(_____) _____

Name _____ Relationship to patient _____ Ph(_____) _____

Name _____ Relationship to patient _____ Ph(_____) _____

PATIENT RELEASE

I, _____ (patient's name), hereby authorize The Orthopaedic Institute and its physicians to release any or all of my patient health information including superconfidential information to the person(s) listed below. (Example: A spouse or relative may be involved in billing and insurance inquiries or medication refills.)

SIGNATURE _____ DATE ___/___/___

Name _____ Relationship to patient _____ Ph(_____) _____

Name _____ Relationship to patient _____ Ph(_____) _____

Name _____ Relationship to patient _____ Ph(_____) _____

PRESCRIPTION HISTORY CONSENT

I agree that The Orthopaedic Institute may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

SIGNATURE _____ DATE ___/___/___

PARENT/GUARDIAN SIGNATURE (IF PATIENT IS A MINOR) _____

PRIVACY NOTICE

In accordance with the Health Insurance Portability and Accountability Act, patients of The Orthopaedic Institute are entitled to and afforded the rights to privacy regarding their health related information as set forth under applicable law. The Orthopaedic Institute will strive to ensure that patient information is used only for purposes authorized by the patient and as otherwise required by law. Upon request we can provide you with a complete copy of our Privacy Policies. Additionally, Patients have a right to review their medical records and furnish comments to their records during normal business hours, upon providing reasonable advance notice.

SIGNATURE _____ DATE ___/___/___