PATIENT INFORMATION

Last Name ______ First Name ______ MI ______

Address ______ City ______ State ______ Zip ______

Home Phone ______ Cell Phone ______ E-Mail Address ______

DOB ______ SSN ______ Race: ☐ Black/African-American ☐ Caucasian/White ☐ Hispanic ☐ Native American ☐ Other

Ethnicity: ☐ White/European ☐ Black/African-American ☐ Latino/Hispanic ☐ Other

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

OrthoOne Clinic MD ______

Referred By ☐ Physician ☐ Friend/Relative ☐ Emergency Room ☐ Yellow Pages ☐ Other

Referring Physician ______ Physician Phone ______

Employer ______ Employer Phone ______

Emergency Contact ______ Contact Phone ______

Contact Address ______ City ______ State ______ Zip ______

RESPONSIBLE PARTY

Last Name ______ First Name ______ MI ______ DOB ______

Address ______ City ______ State ______ Zip ______

Contact Phone ______ E-Mail Address ______ SSN ______

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer ______ Employer Phone ______

INSURANCE INFORMATION

Primary Insurance Co. ______ Policy No. ______ Group No. ______

Policy Holder ______ DOB ______ SSN ______

Policy Holder Address ______ City ______ State ______ Zip ______

Relation to Patient ______ Referral No. ______ Co-Pay ______

Secondary Insurance Co. ______ Policy No. ______ Group No. ______

Policy Holder ______ DOB ______ SSN ______

Policy Holder Address ______ City ______ State ______ Zip ______

My signature authorizes the following: 1) release of PHI (Protected Health Information) to insurance payers as needed/requested to file for payment of all services rendered; 2) payment of insurance(s) benefits to be sent directly to OrthoOne; 3) OrthoOne to request and obtain records from any source necessary in the treatment and/or diagnosis; 4) acknowledgement that OrthoOne will file insurance(s) on your behalf; however, you are financially responsible for payment to OrthoOne for all charges made for services rendered or incurred by you or your dependents not covered by your insurance payer for any reason.; 5) consent for treatment.

Signature (Responsible Party) ______ Date ______

HEALTH HISTORY

Today's Date ____________

Name ____________ Age ____________ DOB ____________

Were you referred by a Physician? ☐ Yes ☐ No   If yes, please provide name ____________

Family Physician ____________ Reason for seeking medical attention ____________

Indicate which side to be treated: ☐ Left ☐ Right ☐ Both   Date of injury or duration of symptoms ____________

What is your current Occupation? ____________

Work Related? ☐ Yes ☐ No   Are you right or left handed? ☐ Right ☐ Left

Have you had any diagnostic studies for this condition, such as MRI, Bone Scan, etc.? Please List: ____________

Have you seen anyone else regarding this condition ☐ Yes ☐ No   If yes, list names and dates: ____________

MEDICAL HISTORY

Have you ever been diagnosed with any of the following medical conditions:

Condition			Condition			Condition		
Asthma	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No	Osteoarthritis	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Alcoholism	☐ Yes	☐ No
Lupus	☐ Yes	☐ No	Migraines	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Bleeding Tendencies	☐ Yes	☐ No	Cancer type ________	☐ Yes	☐ No	Colitis	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Stomach Ulcers	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No	Depression/Anxiety	☐ Yes	☐ No
Polio	☐ Yes	☐ No	Nervous System Disorder	☐ Yes	☐ No	Pelvic Radiation	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	COPD (Chronic Obstructive Pulmonary Disease)	☐ Yes	☐ No

Have you recently had any of the following problems or symptoms :

Symptom			Symptom			Symptom		
Chest Pain	☐ Yes	☐ No	Irregular Heart Beat	☐ Yes	☐ No	Fainting Spells	☐ Yes	☐ No
Breathing Difficulties	☐ Yes	☐ No	Cough	☐ Yes	☐ No	Cough with Blood	☐ Yes	☐ No
Numbness or Tingling	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No	Headaches or Migraines	☐ Yes	☐ No
Vision Changes	☐ Yes	☐ No	Fever or Chills	☐ Yes	☐ No	Unexpected Weight Loss	☐ Yes	☐ No
Abdominal Pain	☐ Yes	☐ No	Nausea or Vomiting	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No
Bloody or Black Tarry Stools	☐ Yes	☐ No	Loss of Control of Bowels	☐ Yes	☐ No	Difficulty Starting Urine	☐ Yes	☐ No
Pain or Burning on Urination	☐ Yes	☐ No	Blood in Urine	☐ Yes	☐ No	Loss of Control of Bladder	☐ Yes	☐ No

Do you currently use any tobacco product? ☐ Yes ☐ No   If yes: Amount per day: ____________ Quit? ____________

Do you drink alcohol? ☐ Yes ☐ No   If yes, how much? Per day ____________ Per week ____________

Family History   Has anyone in your family had: ☐ Heart Disease ☐ Diabetes ☐ Bleeding Problems ☐ Lung Disease ☐ Cancer

If yes to Cancer, what type? ____________ Indicate below which family member.

☐ Mother ☐ Father / Maternal (Mother's) Side: ☐ Grandmother ☐ Grandfather / Paternal (Father's) Side: ☐ Grandmother ☐ Grandfather

Patient Signature ____________

Physician's Signature ____________ Date ____________

Ht. ________ Weight ________ Blood Pressure ________ / ________ Pulse ________

Please indicate if you have had any of the following screenings and the date.

Cervical Cancer Screening: ☐ Yes ☐ No If yes, please indicate date ____________

Breast Cancer Screening: ☐ Yes ☐ No If yes, please indicate date ____________

Colorectal Cancer Screening: ☐ Yes ☐ No If yes, please indicate date ____________

Have you had an Influenza Immunization: ☐ Yes ☐ No If yes, please indicate date ____________

PLEASE LIST ANY ORTHOPAEDIC SURGERIES & DATES	PLEASE LIST ANY OTHER SURGERIES & DATES

Please indicate if you are allergic to any of the following:

☐ Latex ☐ Penicillin ☐ Cephalosporin ☐ Mycins ☐ Sulfa ☐ Tetanus ☐ Iodine

☐ Dyes ☐ Aspirin ☐ Codeine ☐ Morphine ☐ Adheshive Tape ☐ Arthritis Medicine

Foods (please list): ____________

Others: ____________ Please explain allergic reaction: ____________

MEDICATION LIST

MEDICATION NAME	MG/DOSE	FREQUENCY

Pharmacy name for prescriptions ____________ Phone ____________