



Medical History	YES	NO	When	Describe
Heart Disease				
Stroke				
Diabetes				
High Blood Pressure				
Vascular/Circulation Problem				
Blood Clot – leg or lung (DVT/PE)				
Arthritis (please indicate type)				
Stomach/Intestine Problem				
Cancer (please indicate type)				
Bleeding Problem				
Clotting Problem				
Nerve related Problem (type)				
Breathing Problem, Asthma				
Kidney Problem				
Thyroid Problem				
Hepatitis or Liver Disease				
HIV				
Sickle Cell Disease				
Depression/Psychiatric Problem				
Severe Sprains or Dislocations				
Broken Bones				
Other				

### Health Insurance Information

Primary Health Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Secondary Health Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### Automobile Accident Information

Auto Insurance Co: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Address of Insurance Co: \_\_\_\_\_  
Street Number City State Zip Code

Claim Number: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

State Accident Occurred In: \_\_\_\_\_

## Worker's Compensation – On the Job Injury

Date of Injury: \_\_\_\_\_ Was injury reported to supervisor? Yes \_\_\_ No \_\_\_ Claim Number: \_\_\_\_\_

Employer at the time of injury: \_\_\_\_\_

Name of Supervisor: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_  

Street Number
City
State
Zip Code

Worker's Compensation Insurance: \_\_\_\_\_

Worker's Compensation Address: \_\_\_\_\_  

Street Number
City
State
Zip Code

Name of Agent: \_\_\_\_\_ Phone: \_\_\_\_\_

### Patient/Responsible Party Authorization and Waiver

I, \_\_\_\_\_, hereby authorize Suburban Orthopaedic to apply for benefits on my behalf or my dependent's behalf for covered services rendered and I hereby authorize Suburban Orthopaedic to furnish information to insurance carriers concerning my illness and treatments. I also hereby assign Suburban Orthopaedic all payment for services provided. I also understand it is my responsibility to provide all necessary insurance referrals provided by my primary care physician. If I have a HMO policy, I agree to be personally and fully responsible for payments of services deemed necessary in my or my dependent's medical interest and permit a copy of this authorization to be used in place of the original. This document will act as a promissory note. Suburban Orthopaedic reserves the right to add 1% per month interest charge on accounts 45 days overdue.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please list the following:

Current Medications	Past Surgeries (include date)	Allergies
		<input type="checkbox"/> None
		Latex <input type="checkbox"/> Yes <input type="checkbox"/> No

**Social History:**

Single     Married     Divorced     Separated     Widowed     Partner

Do you live alone?             Yes     No

Are you a caregiver for a family member at home?     Yes     No    If yes, whom: \_\_\_\_\_

Do you smoke?                     Yes     No            # of packs per day: \_\_\_\_\_

Do you drink alcohol?             Yes     No            # of drinks per day: \_\_\_\_\_

Do you use drugs?                 Yes     No

**Family History:**

Family Member	Age	Alive	Deceased	List illness or cause of death

**Review of Systems: (circle all that apply to you)**

<b>Gastrointestinal</b>	ulcer colitis	hiatal hernia blood in stool	frequent indigestion
<b>Urinary</b>	Kidney stones Urination is: (circle all that apply) difficult burning	frequent bloody	painful
<b>Neurological</b>	paralysis tingling in arms or legs	weakness seizures	numbness tremor
<b>Skin</b>	chronic rashes infections or boils	itching	sores that don't heal
<b>Vascular, Hematological, and Lymphatic</b>	vein problems anemia easy bruising	phlebitis bleeding problems swollen node	clots calf pain when walking
<b>Cardiac and Pulmonary</b>	chest pain irregular heart beat	shortness of breath heart murmur	chronic cough
<b>Endocrine</b>	weight loss or gain	excessive sweating	
<b>Musculoskeletal</b>	swelling in multiple joints	excessive flexibility	fibromyalgia

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_