SUBURBAN ORTHOPAEDIC, TOTAL JOINT & SPORTS CLINIC

General Information

Patient's Name: _____ Sex: _____ Age: _____
First Middle Last

Patient's Address: _____ Apt: _____
Street Number City State Zip Code

Home Phone: _____ Social Security No: _____ Date of Birth: _____

Occupation: _____ Employed By: _____ Employer's Phone: _____

Employer's Address: _____
Street Number City State Zip Code

Who is responsible for the bill? _____ Relationship _____ Phone: _____

Responsible Party's Address:_____
Street Number City State Zip Code

Social Security #: _____ Employed By: _____ Phone: _____

In Case of Emergency Notify: _____ Phone: _____ Relationship: _____

Patient History

Who referred you to this office? _____ Phone: _____

Who is your Family Physician? _____ Phone: _____

Reason for Visit: _____ Date Symptoms Began: _____

Symptoms caused by an injury? Yes __ No __ **If yes, date of injury:**_____ Work Related: Yes __ No __

Did you report the injury to your employer? Yes __ No __ Injury caused by an Auto Accident? Yes __ No __

If injury, explain what happened: _____

Have you had an: ☐ X-ray _____ ☐ MRI _____ ☐ Nerve Study _____

Have you been treated for this problem by anyone else? Yes __ No __ Whom? _____

List any treatments or tests you have had for this problem:
_____

Medications: _____ Injections: _____

Physical Therapy: _____ Has any of this treatment been helpful? _____

What other specialists have you seen for this problem? _____

Rate your pain on a scale of 1 to 10 (1 = no pain, 10 = worst pain you have ever had): _____

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**
		☐ None
		Latex ☐ Yes ☐ 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)

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

Reviewed By: _____ Date: _____