



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:

- | | | | | | |
|---------------------|--|-------------------------|--|--|--|
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoarthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Alcoholism | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lupus | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraines | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Tendencies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Colitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression/Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Polio | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous System Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pelvic Radiation | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | COPD (Chronic Obstructive Pulmonary Disease) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Have you recently any of the following problems or symptoms :

- | | | | | | |
|------------------------------|--|---------------------------|--|----------------------------|--|
| Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular Heart Beat | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing Difficulties | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cough with Blood | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Numbness or Tingling | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches or Migraines | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Vision Changes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fever or Chills | <input type="checkbox"/> Yes <input type="checkbox"/> No | Unexpected Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Abdominal Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nausea or Vomiting | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bloody or Black Tarry Stools | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of Control of Bowels | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty Starting Urine | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pain or Burning on Urination | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood in Urine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of Control of Bladder | <input type="checkbox"/> Yes <input type="checkbox"/> 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 Adhesive Tape Arthritis Medicine

Foods (please list): _____

Others: _____ Please explain allergic reaction: _____

MEDICATION LIST

MEDICATION NAME	MG/DOSE	FREQUENCY

Pharmacy name for prescriptions _____ Phone _____