

# Patient Information Form

DATE: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Patient SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  M or  F

Marital Status:  S  M  D  W Student Status:  Part-Time  Full-Time

Race:  White  Black  Hispanic  Native Indian  Native Islander  Decline to provide

Ethnicity:  Hispanic  Non- Hispanic  Decline to provide

Emergency Contact: \_\_\_\_\_ Phone # \_\_\_\_\_

## Guarantor Information

Guarantor Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Guarantor SS# \_\_\_\_\_ Guarantor Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## Insurance Information

Primary Insurance \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Subscriber Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Date of Birth \_\_\_\_\_ Subscriber SS# \_\_\_\_\_

Employer: \_\_\_\_\_ COPAY \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Subscriber Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Date of Birth \_\_\_\_\_ Subscriber SS# \_\_\_\_\_

**Authorization for Disclosure of Protected Health Information**

I authorize Victoria Orthopedic Center, LLP to Disclose Protected Health Information to the following person(s)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

**Signature of Patient or Authorized Person** \_\_\_\_\_

**Authorization/Notice of Privacy Practice Acknowledgement**

I, the undersigned, irrevocably assign and transfer benefits to Victoria Orthopedic Center. I authorized Victoria Orthopedic Center, to file claims on my behalf and I assign insurance benefits to Victoria Orthopedic Center. If I am Self Pay, I understand I will be responsible for all charges rendered to by Victoria Orthopedic Center. I understand there will be a \$35.00 returned check fee for all checks returned.

I, understand the Victoria Orthopedic Center may use and disclose my protected health information for purpose of treatment, research, payment and health care operations. I also acknowledge that I received, offered or have received in the past a copy of the Practice's Notice of Privacy Practices.

\_\_\_\_\_ Date \_\_\_\_\_

**Signature of Patient or Authorized Person**

**PATIENT HISTORY**

**TODAY'S DATE:** \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs.  Male  Female

Referring Doctor \_\_\_\_\_ Primary Care Doctor \_\_\_\_\_ Cardiologist \_\_\_\_\_

Other Referring Source \_\_\_\_\_

Did this Injury occur while at work?  Yes  No Is this Auto Accident related?  Yes  No

Do you have a Lawyer for this injury?  Yes  No If so, Who \_\_\_\_\_

What is your primary complaint or injury? \_\_\_\_\_

How did the Injury occur? \_\_\_\_\_

Which side?  Right  Left  Both Which is your Dominant hand?  Right  Left

How long have you had this problem? \_\_\_\_\_

Have you seen a Doctor for this problem?  Yes  No If so, Who \_\_\_\_\_

Have you seen a Pain Management Doctor for this problem?  Yes  No If so, Who \_\_\_\_\_

Have you had any previous surgeries to this area?  Yes  No If so, Who \_\_\_\_\_

MRI Taken  Yes  No Where? \_\_\_\_\_

X-rays Taken  Yes  No Where? \_\_\_\_\_

Have you been treated for this area with:  Physical Therapy  Chiropractor  Acupuncture

Cane/Walker  Massage  Brace  Joint Injection ( Steroid or Synvisc)

Current Symptoms:  Pain  Swelling  Loss of motion  Numbness/Tingling

How do you rate your pain on a scale of 0-10? (10 being worst) \_\_\_\_\_

Are you taking any medication for this problem?  Yes  No

Ibuprofen (Motrin, Advil)  Aleve/Naprosyn  Tylenol  Aspirin  Celebrex

Pain Killers (Vicodin, Lortab, Norco)  Other NSAID  Other

**PATIENT SURGICAL HISTORY**

List previous surgical operations.      Have you had complications from Anesthesia?    Yes    No

	<b>When</b>	<b>Type of Surgery</b>	<b>Surgeon</b>
1			
2			
3			
4			
5			

**PAST MEDICAL HISTORY**

(Check the box if YES and indicate year)

- | <b>Year</b>                    |                         | <b>Year</b>                    |                            |
|--------------------------------|-------------------------|--------------------------------|----------------------------|
| <input type="checkbox"/> _____ | AID/HIV                 | <input type="checkbox"/> _____ | Migraine                   |
| <input type="checkbox"/> _____ | Angina                  | <input type="checkbox"/> _____ | Heart Attack               |
| <input type="checkbox"/> _____ | Arrhythmia (Atrial Fib) | <input type="checkbox"/> _____ | Heart Murmur               |
| <input type="checkbox"/> _____ | Asthma                  | <input type="checkbox"/> _____ | Hepatitis                  |
| <input type="checkbox"/> _____ | Arthritis               | <input type="checkbox"/> _____ | High Blood Pressure        |
| <input type="checkbox"/> _____ | Rheumatoid              | <input type="checkbox"/> _____ | Hypo or Hyperthyroid       |
| <input type="checkbox"/> _____ | Balance Difficulty      | <input type="checkbox"/> _____ | Incontinence Bowel/Bladder |
| <input type="checkbox"/> _____ | Blood Clots             | <input type="checkbox"/> _____ | Lupus                      |
| <input type="checkbox"/> _____ | Pulmonary Embolism      | <input type="checkbox"/> _____ | Osteoporosis               |
| <input type="checkbox"/> _____ | Blood Transfusion       | <input type="checkbox"/> _____ | Phlebitis                  |
| <input type="checkbox"/> _____ | Cancer                  | <input type="checkbox"/> _____ | Psychiatric Disorders      |
| <input type="checkbox"/> _____ | Diabetes                | <input type="checkbox"/> _____ | Seizures                   |
| <input type="checkbox"/> _____ | Emphysema               | <input type="checkbox"/> _____ | Stroke                     |
| <input type="checkbox"/> _____ | Fibromyalgia            | <input type="checkbox"/> _____ | Tuberculosis               |
| <input type="checkbox"/> _____ | Gout                    | <input type="checkbox"/> _____ | Walking Difficulty         |
| <input type="checkbox"/> _____ | Headaches               | <input type="checkbox"/> _____ | Other Please list          |

## FAMILY MEDICAL HISTORY

	<b>AGE</b>	<b>DISEASES</b>	<b>IF Deceased, Cause of Death</b>
Father			
Mother			
Sibling			
Sibling			
Sibling			
Child			
Child			
Child			

## SOCIAL HISTORY

<p><b>Smoking Status</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Current some day smoker</li> <li><input type="checkbox"/> Former smoker</li> <li><input type="checkbox"/> Never smoked</li> <li><input type="checkbox"/> Current every day smoker</li> </ul> <p><b>Tobacco Use</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 1-9 cigarettes per day</li> <li><input type="checkbox"/> 10-19 cigarettes per day</li> <li><input type="checkbox"/> 20-39 cigarettes per day</li> <li><input type="checkbox"/> 40+ cigarettes per day</li> <li><input type="checkbox"/> Cigar smoker</li> <li><input type="checkbox"/> Pipe smoker</li> <li><input type="checkbox"/> Chews tobacco</li> <li><input type="checkbox"/> Snuff user</li> </ul> <p><b>Alcohol Use</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Social</li> <li><input type="checkbox"/> Occasionally</li> <li><input type="checkbox"/> Daily Quantity? _____ Kind? _____</li> </ul> <p><b>Drug</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Occasionally</li> </ul>	<p><b>Exercise</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Occasionally</li> </ul> <p><b>Nutrition</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Regular Diet</li> <li><input type="checkbox"/> Vegetarian</li> <li><input type="checkbox"/> No Restrictions</li> <li><input type="checkbox"/> Other</li> </ul> <p><b>Lives with</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Parents</li> <li><input type="checkbox"/> Siblings</li> <li><input type="checkbox"/> Alone</li> <li><input type="checkbox"/> Spouse</li> <li><input type="checkbox"/> Partner</li> <li><input type="checkbox"/> Roommate</li> <li><input type="checkbox"/> Children</li> <li><input type="checkbox"/> Other</li> </ul> <p>Number in Household _____</p>
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**LIST OF CURRENT MEDICATIONS**

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamins, and Diet supplement products. Also list any medicine you take only on occasion like (Viagra, albuterol, nitroglycerin).

Do you have any of these allergies?  Metal  Latex  Iodine  Other \_\_\_\_\_

List any Medication allergies: \_\_\_\_\_

Pharmacy preference: \_\_\_\_\_

Pharmacy Location: \_\_\_\_\_

MEDICATION (BRAND AND GENERIC NAME)	DOSE	How Often Do You Take the Medication	Reason for Taking	Prescriber

**DATE UPDATED:** \_\_\_\_\_