

THE ORTHOPAEDIC GROUP, LLC

PATIENT MEDICAL HISTORY

Patient Name: _____ Date: ____/____/____

Age____ Height_____ Weight_____ MALE or FEMALE *Handed* RIGHT or LEFT

Onset: Date of Injury- or -onset of symptoms: / /
How did this occur?
Is this a : Motor Vehicle Accident?____ Liability case?____ Work Injury? Other?_____
Describe current problem : Right / Left
FOR YOUR VISIT TODAY DESCRIBE:
Duration? Is your pain constant? No Yes If not, how long does it last and how frequently is it present?
Since symptoms first began how have they progressed?
Is your pain dull, throbbing or sharp? mild, moderate or severe? worsening, improving, or does it come & go?
What improves it? (eg. rest, cold, limb elevation):
What worsens it? (eg. activities or position):
Does it radiate/move to other locations? Where?
When is your pain the worst? Morning, Afternoon, Evening, Awaken from Sleep
Have you had any: Locking, Giving away, Bruising, Numbness, Tingling, Redness, Warmth, Swelling, Fever Or any other symptoms?
Have you:
Injured this area before?
Had Xrays or other tests done? Where? When?
Hospitalization or Surgery for this problem? Where? When?
Therapy or splinting?
a cane, crutches, or walker?
any other orthopaedic problems?
Have you or a relative had treatment here before?
<i>If you are being seen for a BACK problem: Have you had any change in or problems with: Bowel/bladder control or sexual function</i>
Current Medical Problems ----- -----
Past Surgeries ----- ----- -----
All Current MEDICATIONS: _____ _____
LIST all allergies to Food or Medication:
Any Family History of heritable musculoskeletal or connective tissue disorders? No Yes

REVIEW OF SYSTEMS: Do you have any problems with the following: <i>CIRCLE and then DESCRIBE below</i>					
Eyes	High Blood Pressure	Cancer			
Ears/ Nose /Throat	Blood/Bleeding Problems	Arthritis			
Lungs	Diabetes / Thyroid	Polio			
Heart/ Circulation / Vascular	Numbness / Tingling	TB			
Stomach / Digestion / Ulcers	Blackouts / fainting / balance	Epilepsy			
Hepatitis / Liver	Psychological	Allergic / Immunological			
Kidney / Bowel / Bladder	HIV/AIDS	Skin / Rash			
DO YOU smoke? No Yes Packs/day:			Drink Alcohol? No Yes Drinks per day:		
Please list hobbies/special interests:					
What activities does your current condition prevent you from?					
Occupation (List specific duties):			Working now? No Yes (if not, why):		
Is this work related? No Yes					
Name of Doctor requesting consultation:					
Primary Doctor Name/Location:					
Attorney for this problem No Yes Name/Address:					
How often do you exercise? (circle)	Daily	Weekly	Monthly	Rarely	Never
Marital status (circle)	Married	Single	Separated	Divorced	Widowed
Do you have children? No Yes	How many?	Do you live alone?	No Yes		
Patients signature:			Date: / /		
Reviewed By:		MD	Date: / /		
Physical exam: Temperature:		Pulse:	BP:		

Medical Records Reviewed By: _____ MD on / /
 Revised: 9/8/08 _____ MD on / /

The Orthopaedic Group, LLC

Patient Information Form

Patient: _____ Birthdate: _____ SS# _____ - _____ - _____

Address: _____ City: _____ ST _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Are you interested in receiving our orthopedic newsletters? Circle Yes No

Primary Doctor: _____ Address: _____ Phone: _____

Employer: _____ Address: _____

Spouse Name: _____ Birthdate: _____ SS# _____ - _____ - _____

Spouse Employer: _____ Phone: _____

Next of Kin not living with you: _____ Phone: _____

Emergency Contact: _____ Phone: _____

RESPONSIBLE PARTY: (If you are legal guardian or if patient is a minor or student)

Name: _____ Address: _____

INSURANCE INFORMATION:

PRIMARY: _____ ID# _____ GRP# _____

Who subscribes to insurance: _____ Birthdate: _____

SECONDARY: _____ ID# _____ GRP# _____

Who subscribes to insurance: _____ Birthdate: _____

If your Insurance plan requires a **written referral** from your primary doctor, one must be obtained BEFORE the appointment or you will be rescheduled- NO EXCEPTIONS

SIGNATURE REQUIRED-PLEASE READ:

As per your contract and ours with your insurance company, copays are due at the time of visit and are not billable. There will be no exceptions, so please be prepared to pay at time of check in.

Regardless of any insurance coverage I/we may or may not have, it is my/our responsibility to pay the entire bill. In the event that this office needs to obtain legal assistance in collection of any unpaid balance, I/we agree to pay costs and attorney fees as allowable by law and acknowledge receipt of this agreement. I give authorization to release my medical records for billing purposes.

SIGNATURE: _____ **DATE:** _____

MEDICARE PATIENTS ONLY, Please read & sign:

I request that payment under the Medicare/Metrahealth insurance program be made directly to The Orthopaedic Group, LLC on any bills for services rendered by their physicians during my lifetime. I understand that I may be held responsible for a portion of these bills after Medicare has paid the provider, or for charges Medicare does not cover.

SIGNATURE: _____ **DATE:** _____