

**THE ORTHOPEDIC GROUP, P.A. - NEW PATIENT REGISTRATION AND MEDICAL HISTORY**

**PATIENT INFORMATION**

Patient Name (Last, First): \_\_\_\_\_ Sex: M F Date: \_\_\_\_\_  
Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_--\_\_\_\_--\_\_\_\_ Drivers License #: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
Patient's Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Telephone Home: ( ) \_\_\_\_\_--\_\_\_\_\_ Work: ( ) \_\_\_\_\_--\_\_\_\_\_  
Cell: ( ) \_\_\_\_\_--\_\_\_\_\_ Email: \_\_\_\_\_  
The doctor or office staff may leave a message: At home At office On cell phone Marital Status: S / M / D / W  
In emergency notify: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Emergency Contact's Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY** Insurance Company: \_\_\_\_\_ Name of Policyholder: \_\_\_\_\_  
POLICYHOLDER'S Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
Policyholder's Social Security No.: \_\_\_\_-\_\_\_\_-\_\_\_\_ Policyholder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Group #: \_\_\_\_\_ ID#: \_\_\_\_\_ Co-Pay: \_\_\_\_\_

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**SECONDARY** Insurance Company: \_\_\_\_\_ Name of Policyholder: \_\_\_\_\_  
POLICYHOLDER'S Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
Policyholder's Social Security No.: \_\_\_\_-\_\_\_\_-\_\_\_\_ Policyholder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Group #: \_\_\_\_\_ ID#: \_\_\_\_\_

**PRIMARY CARE PROVIDER AND PHARMACY**

\*\*In order to be seen by the doctor, a primary care provider or referring physician must be provided\*\*

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ Address: \_\_\_\_\_  
Referred by:  Primary Care Physician  Insurance Directory  Hospital  Other (please list \_\_\_\_\_)  
PHARMACY: \_\_\_\_\_ Location: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

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PATIENT NAME (Last, First): \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

**PRESENT PROBLEM**

Reason for visit (What body part is bothering you?): \_\_\_\_\_

When did you first develop this problem (date or number of weeks/months you have had problem)? \_\_\_\_\_

The problem is a result of:  Car Accident  Work Injury  Sport Injury  Slip & Fall  No known injury  Other \_\_\_\_\_

If result of a car or work accident, please give specific information. (For example, driver of car hit by another car, fall at work with a twist to knee, etc. Names of other parties or location of accident not necessary) \_\_\_\_\_

Is this the first time you have had this problem?  Yes  No Have you been treated for this problem before?  Yes  No

Brief summary of treatment up to this point. Please give dates of any test, surgeries, or hospital admissions. \_\_\_\_\_

Names & location of any physician who has treated you for this problem. \_\_\_\_\_

Which is your dominant hand?  Right  Left  Ambidextrous

**PAST ORTHOPEDIC HISTORY**

Please indicate any orthopedic/bone problems you have or have had in the past:  No previous orthopedic problems

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Sprain               | <input type="checkbox"/> Tendonitis          | <input type="checkbox"/> Bursitis           | <input type="checkbox"/> Arthritis          |
| <input type="checkbox"/> Knee ligament injury | <input type="checkbox"/> Knee cartilage tear | <input type="checkbox"/> Rotator cuff tear  | <input type="checkbox"/> Foot/Hand Disorder |
| <input type="checkbox"/> Fracture             | <input type="checkbox"/> Joint Dislocation   | <input type="checkbox"/> Neck/Low back pain | <input type="checkbox"/> Herniated disc     |

Please specify: \_\_\_\_\_

**PAST MEDICAL HISTORY**

Please indicate any medical problems you have or have had in the past:  No medical problems

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Cancer (Type _____)          | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Heart Failure       | <input type="checkbox"/> Fibromyalgia      | <input type="checkbox"/> Depression                   | <input type="checkbox"/> High Blood Pressure  |
| <input type="checkbox"/> Abnormal Heart Beat | <input type="checkbox"/> Lyme's Disease    | <input type="checkbox"/> Kidney Disease               | <input type="checkbox"/> High Cholesterol     |
| <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Gout              | <input type="checkbox"/> Hepatitis / Liver Disease    | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Blood Clot / DVT  | <input type="checkbox"/> Peptic Ulcers / GI Bleed     | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Osteoarthritis    | <input type="checkbox"/> Other (please specify _____) |   |

**PAST SURGICAL HISTORY**

Please indicate any surgeries you have had in the past:  No prior surgery

For any surgeries, please list an approximate date of when the surgery was performed.

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Appendectomy          | <input type="checkbox"/> Tonsillectomy           | <input type="checkbox"/> Hernia Repair        | <input type="checkbox"/> C-Section         |
| <input type="checkbox"/> Joint replacement     | <input type="checkbox"/> Knee arthroscopy        | <input type="checkbox"/> Shoulder arthroscopy | <input type="checkbox"/> Back/neck surgery |
| <input type="checkbox"/> Cardiac Bypass        | <input type="checkbox"/> Cardiac Catheterization | <input type="checkbox"/> Gastric Bypass       | <input type="checkbox"/> Lung Surgery      |
| <input type="checkbox"/> Other (specify _____) |  |   |  |

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PATIENT NAME (Last, First): \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

**FAMILY HISTORY**

Does anyone in your immediate family have a history of any of the following?  No significant family history

- Asthma                       Bleeding Disorder                       Cancer (Type \_\_\_\_\_)                       High Blood Pressure
- Kidney Disease                       Heart Attack                       High Cholesterol                       Heart Disease
- Gout                       Rheumatoid Arthritis                       Stroke                       Other (specify \_\_\_\_\_)

**ALLERGIES**

Are you allergic to any medications?  None      If yes, please list: \_\_\_\_\_

**MEDICATIONS**

Please list ALL medications and dosages you are currently taking (include over-the-counter medicines like Tylenol, Advil, etc):  
If you have a list of your medicines, you may give it to the receptionist to copy  No medications

_____	_____	_____
_____	_____	_____
_____	_____	_____

**SOCIAL HISTORY**

What is your occupation? \_\_\_\_\_ Does your job involve:  desk work  manual labor  standing

Do you or did you ever use any of the following?

- |                     | Yes                      | No                       |   |
|---------------------|--------------------------|--------------------------|---|
| Cigarettes          | <input type="checkbox"/> | <input type="checkbox"/> | If yes, # of packs/day _____ For how many years _____ If quit, how long ago _____ |
| Other Tobacco Forms | <input type="checkbox"/> | <input type="checkbox"/> | If yes, please specify type and quantity _____                                    |
| Alcohol             | <input type="checkbox"/> | <input type="checkbox"/> | If yes, # of drinks per day or week _____   |
| Other Drugs         | <input type="checkbox"/> | <input type="checkbox"/> | If yes, please specify _____  |

**REVIEW OF SYSTEMS**

Do you currently have a problem in any of the following areas :

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Nervous system  | <input type="checkbox"/> Eyes               | <input type="checkbox"/> Ears, Nose, or Throat     | <input type="checkbox"/> Heart or blood vessels   |
| <input type="checkbox"/> Lungs           | <input type="checkbox"/> Stomach/Intestines | <input type="checkbox"/> Kidney, bladder, genitals | <input type="checkbox"/> Muscle, bones, or joints |
| <input type="checkbox"/> Skin or breasts | <input type="checkbox"/> Psychiatric        | <input type="checkbox"/> Glands or Hormones        | <input type="checkbox"/> Blood                    |

Please provide details on any item(s ) checked: \_\_\_\_\_

**AUTHORIZATION and PRIVACY POLICY**

I hereby give authorization to The Orthopedic Group, P.A. and its staff for **treatment and for the release of medical information** necessary to process claims, payments, and appeals. I agree that a photocopy or fax of this form may be used in place of the original.

I acknowledge that I have received a copy of the *Notice of Privacy Practice* of The Orthopedic Group, P.A.

PATIENT SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Please Print Name: \_\_\_\_\_

-----\*FOR OFFICE USE ONLY\*-----

Reviewed By: \_\_\_\_\_ M.D. Date: \_\_\_\_\_