ADVANCED ORTHOPAEDIC SPECIALISTS

Patient Information Sheet
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This section is for office use.
☐ New patient ☐ Established patient

Date: _____/_____/_________

Patient Information

Last Name First Name Middle Initial

Address

City State Zip Code

Number to call to remind of appointment: Home Phone Work Phone Cell Phone

E-mail Address Marital Status

Social Security Number: _____ - _____ - _______ Date of Birth: _____ / _____ / _______ Sex: ☐ Male ☐ Female

Occupation:____

Primary Insurance

What is the name of your insurance provider: ☐ Medicare ☐ Medicaid ☐ BC/BS ☐ Other

Other (Please Specify): ____ Effective Date: _____ / _____ / _______

/

Name of policy holder: Last Name First Name Middle Initial Date of birth Relationship to Patient

Address of policy holder if not the same as Patient's

City State Zip Code

Phone: (_______) _______ - __________
Social Security Number of Policy Holder: ______ - ______ - _________

Insurance Identification Number: ______________________________ Group Identification Number: ______________________________

Secondary Insurance

What is the name of your insurance provider: ☐ Medicare ☐ Medicaid ☐ BC/BS ☐ Other

Other (Please Specify): ____ Effective Date: _____ / _____ / _______

/

Name of policy holder: Last Name First Name Middle Initial Date of birth Relationship to Patient

Address of policy holder if not the same as Patient's

City State Zip Code

Phone: (_______) _______ - __________
Social Security Number of Policy Holder: ______ - ______ - _________

Insurance Identification Number: ______________________________ Group Identification Number: ______________________________

Employment

Status: ☐ Retired ☐ Full-Time ☐ Part-Time ☐ Unemployed Other: ______________________________

/

Name of Employer (Company Name) Occupation

Phone Number: (_____) _____ - __________

Address

City State Zip Code

Emergency Contact/Parental Information

Last Name First Name Middle Initial

Address

City State Zip Code

Home Phone Work Phone Cell Phone

E-mail Address Relationship

Primary Care Physician (PCP): ____

Referring Physician / or Name: ____

Medications

List all medications you take, prescription and nonprescription: No medications ☐

Medication

1. ______________________ 9. ______________________
2. ______________________ 10. ______________________
3. ______________________ 11. ______________________
4. ______________________ 12. ______________________
5. ______________________ 13. ______________________
6. ______________________ 14. ______________________
7. ______________________ 15. ______________________
8. ______________________ 16. ______________________

Medication/Food Allergies

______________________ ______________________

______________________ ______________________

______________________ ______________________

Past Medical History

Please indicate if you have ever experienced any of the following conditions.

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
❑	❑	Anemia	❑	❑	Heart Attack	❑	❑	Sleep Apnea
❑	❑	Asthma	❑	❑	Heart Disease	❑	❑	Stomach Ulcer
❑	❑	Blood Clots / DVT	❑	❑	Hepatitis	❑	❑	Stroke (CVA) (TIA)
❑	❑	Cancer Type: ________________	❑	❑	High Blood Pressure	❑	❑	Thyroid Disease
			❑	❑	High Cholesterol	❑	❑	Tuberculosis
❑	❑	Congestive Heart Failure	❑	❑	Irritable Bowel (IBS)	❑	❑	Other:_______________ ____________________
❑	❑	COPD	❑	❑	Kidney Disease			
❑	❑	Crohn's Disease	❑	❑	Migraines			
			❑	❑	Multiple Sclerosis			
❑	❑	Depression	❑	❑	Osteoarthritis			
❑	❑	Diabetes	❑	❑	Parkinson's Disease			
❑	❑	Esophageal Reflux	❑	❑	Rheumatoid Arthritis			
❑	❑	Gout	❑	❑	Seizures / Epilepsy			

Surgical History

Surgery	Physician	Date
____	____________________________________	______________
____	____________________________________	______________
____	____________________________________	______________
____	____________________________________	______________
____	____________________________________	______________
____	____________________________________	______________
____	____________________________________	______________
____	____________________________________	______________
____	____________________________________	______________

Family History

Please check if any family member has had any of the following conditions: OR: ❑ **Adopted**

Yes	No	Condition	**Family Member**	**COMMENTS**
❑	❑	Blood Clots (DVT)	_____________________________	
❑	❑	Heart Disease	_____________________________	
❑	❑	Cancer Type: _______________	_____________________________	
❑	❑	Diabetes	_____________________________	
❑	❑	High Cholesterol	_____________________________	
❑	❑	Hypertension	_____________________________	
❑	❑	Kidney Disease	_____________________________	
❑	❑	Osteoarthritis	_____________________________	
❑	❑	Osteoporosis	_____________________________	
❑	❑	Peripheral Vascular Disease	_____________________________	
❑	❑	Seizures/Epilepsy	_____________________________	
❑	❑	Stroke (CVA)	_____________________________	
❑	❑	Other:	_____________________________	

Race/Ethnicity

- ❑ American Indian/Alaskan Native
- ❑ Asian
- ❑ Black/African American
- ❑ Hispanic/Latino
- ❑ Native Hawaiian/Other Pacific Islander
- ❑ White
- ❑ Unknown
- ❑ Other ________________

Language

What is your primary language? ____

Social History

Do you use tobacco ❑ Yes ❑ No ❑ Former Type of tobacco used _______________/_______________
Packs per day _______________________________________ Years smoked ___________________ Year Quit _____________
Other Tobacco units per day (cans, cigars, etc) ____
Units per day _______________________ Years used ________________ Year Quit ______________

Do you drink caffeine ❑ Yes ❑ No Type _____________________ Amount Daily __________

Do you drink alcohol ❑ Yes ❑ No ❑ Former Year Quit _____________
Type ___________________________________ How much per week ____
Amount ________________________________ Last Drink ____

Do you have a history of substance abuse?

- ❑ Yes
- ❑ No

If yes, please explain ____
____
____

Do you have a history of prescription drug misuse?

- ❑ Yes
- ❑ No

If yes, please explain ____
____
____

Hand Dominance: ❑ right ❑ left ❑ ambidextrous

Why are you seeing the doctor today? ❑ Right /❑ Left ❑ Knee, ❑ Shoulder, ❑ Hip, ❑ Other _____________

Date of Injury/accident if known: _______________________

Reason for visit:
____
____

I understand and agree that if I have no insurance coverage or if my claim is a result of a third party injury, payment is due at the time of service.

I understand and agree that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Advanced Orthopaedic Specialists.

I authorize Advanced Orthopaedic Specialists to release pertinent medical information to my insurance company when requested, to facilitate payment of a claim.

I understand and agree that it is my responsibility to inform the staff of Advanced Orthopaedic Specialists as to which hospital or outside facility is in my insurance network.

I give permission for Advanced Orthopaedic Specialists to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

Signature of Patient or Responsible Party: ________________________________Date:_______

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

PERMISSION TO GIVE MEDICAL INFORMATION

I, ________________________________, have received a copy of Advance Orthopaedic Specialists' Notice of Privacy Practices.

I hereby authorize Advanced Orthopedic Specialists to give the following people information concerning my health and well being, regarding appointment times, test/lab results, medications, procedures, and any other information regarding my health.

__Spouse Name: __________________________________

__Significant Other Name: __________________________________

__A Specified Person Name: __________________________________
(Name and Relationship)

Name: __________________________________
(Name and Relationship)

__ I give permission to leave a message on my home answering machine or work voice mail.

__I understand there will be a fee of $5 for the first 5 pages and $0.25 per page thereafter for records requested by the patient.

I understand I may revoke this consent at any time by giving written notice to the person or organization making the disclosure.

____ __________________
Signature of Patient or Guardian **Date**