PATIENT INFORMATION

Date _____ Social Security # _____
Name _____ Birth Date _____
Home Address _____ Marital Status _____
_____Age ____ Height _____ Weight _____
_____
Home Phone _____Email _____

Emergency Contact Name and Phone_____

How did you hear about us? _____

Family Physician _____ Employer _____
Address _____Occupation _____
_____Address _____
_____ _____
Phone _____ Phone _____

If the patient is under 21 years old or mentally incompetent, please complete the following:

Guardian _____ Relationship to Patient _____
Bill to Address _____

INSURANCE INFORMATION

Insurance Carrier _____ ID # _____

Auto Accident Carrier _____ Date of Accident _____
Contact Person _____ Phone # _____ Claim # _____

Worker's Comp Carrier _____ Date of Injury _____
Contact Person _____Phone # _____ Claim # _____

MEDICAL HISTORY INFORMATION

Please list any operations that you have had. If possible, please give the year, the name of the procedure and surgeon, and the hospital where it was done.

YEAR PROCEDURE SURGEON HOSPITAL

_____
_____
_____
_____
_____
_____

Have you ever been admitted to a hospital other than for a surgery? List the reason and year if possible.

_____
_____
_____
_____

Please circle if you have had any of the following conditions. What medications are you currently taking?

Cancer Type: _____	Asthma/Lung Disease	_____
Hepatitis	High Blood Pressure	_____
Jaundice	Blood Clot Formation	_____
Bleeding Tendency	Psychiatric Illness	_____
Heart Trouble	Stomach Ulcer	_____
Heart Attack	Tuberculosis	_____
Stroke	Gout	_____
Current Infections	Seizures	_____
Low Thyroid	Hereditary Defects	_____
Diabetes	Vascular Disease	
Kidney Disease		

Do you have any other medical conditions that you think we should know about:

_____

Are you allergic to Penicillin? Yes No Are you allergic to Latex? Yes No

What reaction did you have? _____

If allergic to other medications or have other allergies, please list them and the reaction you had:

_____
_____

Do you smoke? Yes No For how many years? _____How many packs per day? _____

On average, how many alcoholic drinks do you have a week? 0 1-5 6-10 11-15 >16

Other recreational drugs? Yes No Have you ever had a MRSA infection? Yes No

Who lives at home with you? _____

REVIEW OF MEDICAL CONDITIONS

Do you have any of these conditions? (Please circle)

General Symptoms

Recent weight change .....Yes
Fever .....Yes
Fatigue .....Yes
Headaches .....Yes

Eyes

Eye disease or injury.....Yes
Wear glasses/contact lenses .....Yes
Blurred or double vision .....Yes
Glaucoma .....Yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing .....Yes
Earaches or drainage .....Yes
Chronic sinus problems or rhinitis .....Yes
Nose bleeds.....Yes
Mouth sores .....Yes
Bleeding gums.....Yes
Bad breath or bad taste .....Yes
Sore throat or voice change .....Yes
Swollen glands in neck .....Yes

Cardiovascular and Heart

Heart trouble.....Yes
Chest pain or angina pectoris .....Yes
Palpitation.....Yes
Shortness of breath with walking
or lying flat .....Yes
Swelling of feet, ankles or hands .....Yes

Respiratory and Breathing

Chronic or frequent coughs .....Yes
Spitting up blood.....Yes
Shortness of breath.....Yes
Asthma or wheezing .....Yes

Gastrointestinal

Loss of appetite .....Yes
Change in bowel movements .....Yes
Nausea or vomiting .....Yes
Frequent diarrhea .....Yes
Painful bowel movements or
constipation .....Yes
Rectal bleeding or blood in stool .....Yes
Abdominal pain or heartburn .....Yes
Peptic ulcer (stomach or duodenal).....Yes

Genitourinary

Frequent urination.....Yes
Burning or painful urination.....Yes
Blood in urine.....Yes
Change in force of strain
when urinating .....Yes
Incontinence or dribbling.....Yes
Kidney stones .....Yes

Musculoskeletal

Joint pain.....Yes
Joint stiffness or swelling .....Yes
Weakness of muscle or joints .....Yes
Muscle pain or cramps .....Yes
Back pain .....Yes
Cold extremities .....Yes
Difficulty walking .....Yes

Skin and Breast

Rash or itching .....Yes
Change in skin color .....Yes
Change in hair or nails .....Yes
Breast pain .....Yes
Breast lump.....Yes
Breast discharge .....Yes
Varicose veins .....Yes

Neurological

Frequent or recurring headaches .....Yes
Light-headedness or dizziness.....Yes
Convulsions or seizures .....Yes
Numbness and tingling sensation .....Yes
Tremors.....Yes
Stroke .....Yes
Head Injury .....Yes
Paralysis .....Yes

Psychiatric

Memory loss or confusion.. .....Yes
Nervousness.....Yes
Depression .....Yes
Insomnia.....Yes

Endocrine

Glandular or hormone problem.....Yes
Thyroid disease .....Yes
Diabetes .....Yes
Heat or cold intolerance.....Yes
Skin becoming dryer .....Yes
Change in hat or glove size .....Yes
Excessive thirst or urination .....Yes

Hematologic/Lymphatic

Slow to heal after cuts.....Yes
Bleeding or bruising tendency.....Yes
Anemia.....Yes
Phlebitis .....Yes
Past transfusions.....Yes
Enlarged glands .....Yes

Allergic

History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics .....Yes
Morphine, Demerol, other narcotics .....Yes
Novocaine or other anesthetics .....Yes
Aspirin or other pain remedies.....Yes
Tetanus antitoxin or other serums.....Yes
Iodine, methylate or other antiseptics.....Yes
Known food allergies _____

Family Medical History

	Age	Disease	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

PLEASE READ AND SIGN THE INSURANCE AUTHORIZATION

Commercial Insurance: required for all commercial carriers excluding Workman's Compensation and Auto Carriers:

I authorize Groff Orthopaedics and Sports Medicine, to release to my insurance company any medical information necessary to process my medical claim. I hereby authorize payment to Groff Orthopaedics and Sports Medicine, of any benefit due me under my insurance plan. I understand that I am responsible for non-covered charges. This authorization or copy of it shall be valid for 12 months.

Signature _____ Date _____

Medicare Authorization:

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information or other information to provide to the Medicare Program and/or any of my insurance carriers any information needed for this or a related claim. I request payment be made directly to the provider.

Signature _____ Date _____

Workers Compensation/Auto Insurance Authorization:

I authorize Groff Orthopaedics and Sports Medicine, to release to my worker's compensation/ auto insurance company any medical information necessary to process my medical claim. If, for any reason, payment is denied, I authorize Groff Orthopaedics and Sports Medicine, to bill my primary health insurance and/or myself for non-covered charges.

Signature _____ Date _____