SOUTH HILLS ORTHOAPEDIC SURGERY ASSOCIATES, PC

PATIENT INFORMATION FORM

DATE _____

Name _____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Email _____

Social Security _____ Male _____ Female _____ Marital Status _____

Race _____ Hispanic_____ Non- Hispanic_____ Primary language spoken _____

Employer _____ Occupation _____

Address _____ Phone _____

Family Physician Name _____ Phone _____

Office Location_____

Pharmacy Name _____ Phone _____

Pharmacy Location _____

Primary Insurance _____ ID# _____ Group# _____

Co-Pay_____ Subscriber Name _____ Birthdate _____

Secondary Insurance_____ID# _____ Group# _____

Co-Pay_____ Subscriber Name _____ Birthdate _____

Is your visit today due to an accident? Yes ____ No ____ If yes: Work _____ Auto _____Sports _____ Other _____

Date of accident _____Type of injury _____

Work Comp/Auto Accident Insurance _____

Address _____

Claim# _____ Adjuster _____ Phone _____

IF PATIENT IS UNDER 18 YEARS OLD:

Parent/Guardian Name _____ Phone _____

SOUTH HILLS ORTHOAPEDIC SURGERY ASSOCIATES, PC

PATIENT HEALTH HISTORY FORM **DATE** _____

Name _____ **HEIGHT** ____ **FT** ____ **IN** **WEIGHT** _____ **LBS**

Reason for visit: _____

Were you referred to us by another physician? _____ **Physician Name** _____

PERSONAL MEDICAL HISTORY - *Please check if you **HAD** or if you **CURRENTLY HAVE SYMPTOMS OF**:*

	Diabetes		Blood disorder
	Cancer		Hypertension
	Thyroid disease		Ulcers/Stomach problems
	Kidney disease		Rheumatoid Arthritis/Lupus
	Liver problems		Glaucoma
	Arthritis		Heart attack/Angina/Heart disease
	Epilepsy/Seizures		OTHER:

CURRENT MEDICATIONS *INCLUDING OVER THE COUNTER MEDICATIONS OR DIETARY SUPPLEMENTS*:

1._____ 4._____ 7._____

2._____ 5._____ 8._____

3._____ 6._____ 9._____

ALLERGIES *PLEASE SPECIFY*: _____

SURGICAL HISTORY:

1._____ 4._____

2._____ 5._____

3._____ 6._____

	ALCOHOL USE
	1-2 drinks/day
	1-2 drinks/week
	3 or more drinks/day
	Rarely drinks
	Never drinks

	TOBACCO USE
	Current smoker/ amount
	# of years
	Former smoker
	Chew/Snuff
	Never

	ACTIVITY LEVEL/LIFESTYLE
	Very active
	Active
	Moderate activity
	Little activity
	Sedentary (none)

FAMILY MEDICAL HISTORY – Please check if you have a family history of:

	HEART DISEASE/STROKE	RELATIONSHIP:
	DIABETES	RELATIONSHIP:
	BLOOD CLOTS/DVT	RELATIONSHIP:
	CANCER	RELATIONSHIP:
	OTHER:	RELATIONSHIP:

PLEASE CIRCLE ANY SYPMTOMS YOU ARE EXPEREINCING AT THIS TIME:

CONSTITUTION	Fever / Chills / Weight change / Fatigue / Headaches
EAR-NOSE-THROAT	Earaches / Sinus problems / Nosebleeds / Sore throat / Bleeding gums / Mouth sores
CARDIOVASCULAR	Chest pain / Heart problems / Heartbeat changes / Swelling in hands & feet
RESPIRATORY	Asthma / Wheezing / Shortness of breath / Cough / Spitting up blood
GASTROINTESTINAL	Change in bowel habits / Vomiting / Nausea / Heartburn / Loss of appetite
GENITO-URINARY	Frequent urination / Painful urination / Blood in urine / Kidney stones / Incontinence
PSYCHIATRIC	Memory loss / Confusion / Depression / Sleep problems
SKIN	Skin rash / Lesions
NEUROLOGICAL	Light-headed / Dizzy / Seizures / Numbness / Tingling / Stroke / Paralysis / Tremor
MUSCULOSKETAL	Joint pain / Stiffness / Weakness / Cramps / Muscle pain
ENDOCRINE	Diabetes / Thyroid problems / Hot or cold intolerance / Hormone problems
HEMATOLOGIC	Easy to bruise or bleed / Anemia / Transfusion / Swollen glands

REVIEWED BY:_____**DATE:** __/__/____ **REVIEWED BY:**_____**DATE:** __/__/____

PATIENT NAME:_____ DATE OF BIRTH:_____

GUARDIAN NAME (IF PATIENT IS UNDER 18 YEARS OLD):_____

ACKNOWLEDGEMENT AND CONSENT

I have received the Notice of Privacy Practices for South Hills Orthopaedic Surgery Associates, PC. South Hills Orthopaedic Surgery Associates, PC is authorized to use and disclose health information about _____(patient name) for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize South Hills Orthopaedic Surgery Associates, PC permission to use and/or disclose health information about _____(patient name) for purposes of treatment and billing

I hereby assign to South Hills Orthopaedic Surgery Associates, PC all payments from my insurance company for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance company.

SOUTH HILLS ORTHOPAEDIC SURGERY ASSOCIATES PC CONFIDENTIALITY AGREEMENT

Please list the family members or other persons, if any, whom we may inform about you or your dependents general medical condition ,or in the event of emergency ,and diagnosis at time of service:

Name_____Relationship_____Phone_____
Email_____

May we leave a message (including voicemail) regarding appointments at all the phone numbers listed on your registration form?

____YES ____NO

If NO please list the phone numbers where we may contact you._____

I HEREBY AGREE TO THE INFORMATION LISTED ABOVE BY SOUTH HILLS ORTHOPAEDIC SURGERY ASSOCIATES PC AND/OR GIVE AUTHORIZATION TO BE CONTACTED ON THE NUMBER ON MY REGISTRATION FORM OR LISTED BY MYSELF ABOVE:

_____ _____

Patient or Parent/Guardian Signature Date