

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 ORTHOPAEDIC 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:**

<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Blood disorder
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	Ulcers/Stomach problems
<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	Rheumatoid Arthritis/Lupus
<input type="checkbox"/>	Liver problems	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Heart attack/Angina/Heart disease
<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	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	
<input type="checkbox"/>	1-2 drinks/day
<input type="checkbox"/>	1-2 drinks/week
<input type="checkbox"/>	3 or more drinks/day
<input type="checkbox"/>	Rarely drinks
<input type="checkbox"/>	Never drinks

TOBACCO USE	
<input type="checkbox"/>	Current smoker/ amount
<input type="checkbox"/>	# of years
<input type="checkbox"/>	Former smoker
<input type="checkbox"/>	Chew/Snuff
<input type="checkbox"/>	Never

ACTIVITY LEVEL/LIFESTYLE	
<input type="checkbox"/>	Very active
<input type="checkbox"/>	Active
<input type="checkbox"/>	Moderate activity
<input type="checkbox"/>	Little activity
<input type="checkbox"/>	Sedentary (none)

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

<input type="checkbox"/>	HEART DISEASE/STROKE	RELATIONSHIP:
<input type="checkbox"/>	DIABETES	RELATIONSHIP:
<input type="checkbox"/>	BLOOD CLOTS/DVT	RELATIONSHIP:
<input type="checkbox"/>	CANCER	RELATIONSHIP:
<input type="checkbox"/>	OTHER:	RELATIONSHIP:

**PLEASE CIRCLE ANY SYMPTOMS YOU ARE EXPERIENCING 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