ORTHOPEDIC CENTER OF THE DAKOTAS

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PLEASE PRINT IN BLACK INK - PRESS HARD.

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The following information is very important to your health. Please take the time to fully and accurately fill out this form.

PATIENT INFORMATION

Chart # _____

Patient Name _____

Mailing Address _____

_____

City, State, Zip _____

Area Code/Phone No. _____

Cell Phone No. _____

Email Address _____

Social Security No. _____

Patient Sex M F Birthdate_____Age ____

Marital Status S M D W O Student Status (P-F)

Are you Left or Right handed? _____

Race: ❑ Caucasian ❑ African American ❑ Hispanic ❑ American Indian ❑ Asian ❑ Other_____

Ethnicity: ❑ Filipino ❑ Hispanic/Latino ❑ Non Hispanic/ Latino ❑ Declined

Language Preferred _____

Emergency Contact (not living with you) _____

Emergency Phone _____

Relation to Patient _____

Patient Employer _____

Patient Occupation _____

Address _____

City, State, Zip_____Phone _____

Employment Status Full-Time _____Part-Time_____

Party Responsible for Payment of Personal Balance (If patient is under the age of 18)

Guarantor Information Same As Above ❑

Guarantor Name _____

Address_____

City, State/Zip Code _____

Guarantor Area Code/Phone No. _____

Patient Relationship to Guarantor _____

Guarantor Employer _____

Address_____Phone _____

Guarantor Social Security No. _____

Guarantor Birthdate_____Sex _____

Spouse's Information (if applicable)

Name_____Social Security No._____Birthdate_____

Employer Name_____Occupation_____

Street, City, State, Zip_____Area Code/Phone No._____

ARE YOU ELIGIBLE FOR ANY VETERAN'S BENEFITS? ❑ YES ❑ NO

ARE YOU ELIGIBLE FOR INDIAN HEALTH BENEFITS OR A MEMBER OF A NATIVE AMERICAN TRIBE? ❑ YES ❑ NO

ARE WE SEEING YOU FOR A WORK RELATED INJURY TODAY? ❑ YES ❑ NO

IF YES, HAVE YOU FILED A FIRST REPORT OF INJURY WITH YOUR EMPLOYER? ❑ YES ❑ NO

ARE WE SEEING YOU FOR A LIABILITY OR MOTOR VEHICLE ACCIDENT TODAY? ❑ YES ❑ NO

IF YES, HAVE YOU FILED A CLAIM WITH YOUR LIABILITY OR MOTOR VEHICLE INSURANCE? ❑ YES ❑ NO

IF MEDICARE PATIENT ARE YOU OR SPOUSE CURRENTLY EMPLOYED? ❑ YES ❑ NO

IF YES, DOES THE EMPLOYER HAVE MORE THAN 20 EMPLOYEES? ❑ YES ❑ NO

Insurance Information- PLEASE PRESENT YOUR INSURANCE CARD TO BE SCANNED BY THE RECEPTIONIST

Primary Insurance

Name of Insurance Company _____

Name of Policy Holder_____

Policy Holder Social Security No. _____

Policy Holder Birthdate _____

Relationship to Patient_____

Effective Date_____

Secondary Insurance

Name of Insurance Company _____

Name of Policy Holder_____

Policy Holder Social Security No. _____

Policy Holder Birthdate _____

Relationship to Patient_____

Effective Date_____

(SEE BACK FOR MORE INFORMATION)

PATIENT'S MEDICAL HISTORY

Date of Birth:_____ **Height:** _____ **Weight:** _____ **Family Pharmacy:** _____

Referring Physician/Clinic _____**Family Doctor:** _____

Description of Problem: ❑ **Right** ❑ **Left** _____ **Date of Injury:**_____

How Did Injury Occur: _____

Current Medications/Vitamins: **(including aspirin and herbal supplements)** _____

_____

Medical Allergies: _____ **Previous Orthopedic Injuries:**_____

Previous Surgeries of any kind: ❑ **Appendectomy** ❑ **Gall Bladder** ❑ **Pacemaker** ❑ **Cardiac Bypass** ❑ **Hernia Repair** ❑ **Tonsils** ❑ **C-Section** ❑ **Hysterectomy** ❑ **Cataract** ❑ **Gastric Bypass**
❑ **Orthopedic** _____ ❑ **Other** _____

SOCIAL HISTORY:	**If yes, how many?**	**How Long?**	**FAMILY HISTORY OF ILLNESS/DISEASE: (cancer, diabetes, etc.)**
Alcohol Use? ❑ **Yes** ❑ **No**	_____	_____	_____
Tobacco Use? ❑ **Yes** ❑ **No**	_____	_____	_____

Any Likelihood of Current Pregnancy? ❑ **Yes** ❑ **No**

PATIENT REVIEW OF SYSTEMS: Are you now or have you ever been treated for any of the following:

INTEGUMENTARY:
- **Skin Ulcers** ❑ **Yes** ❑ **No**
- **Skin Disease** ❑ **Yes** ❑ **No**
- **Eczema** ❑ **Yes** ❑ **No**
- **Psoriasis** ❑ **Yes** ❑ **No**

EYES:
- **Glaucoma** ❑ **Yes** ❑ **No**
- **Blurred/Double Vision** ❑ **Yes** ❑ **No**

EARS, NOSE, THROAT & MOUTH (ENT):
- **Dizziness** ❑ **Yes** ❑ **No**
- **Sinus Infections** ❑ **Yes** ❑ **No**
- **Hearing Loss** ❑ **Yes** ❑ **No**

RESPIRATORY:
- **Asthma** ❑ **Yes** ❑ **No**
- **Tuberculosis** ❑ **Yes** ❑ **No**
- **Shortness Breath** ❑ **Yes** ❑ **No**
- **Emphysema** ❑ **Yes** ❑ **No**
- **Recent Cold/Flu** ❑ **Yes** ❑ **No**
- **Home Oxygen** ❑ **Yes** ❑ **No**
- **Sleep Apnea/CPAP** ❑ **Yes** ❑ **No**

PSYCHIATRIC:
- **Depression** ❑ **Yes** ❑ **No**
- **Anxiety** ❑ **Yes** ❑ **No**

CARDIOVASCULAR:
- **High Blood Pressure** ❑ **Yes** ❑ **No**
- **Heart Disease** ❑ **Yes** ❑ **No**
- **Vascular Disease** ❑ **Yes** ❑ **No**
- **Heart Attack** ❑ **Yes** ❑ **No**
- **Chest Pain** ❑ **Yes** ❑ **No**
- **Pace Maker** ❑ **Yes** ❑ **No**
- **Congestive Heart Failure** ❑ **Yes** ❑ **No**
- **Stress Test** ❑ **Yes** ❑ **No**
  Year _____ **Where**_____

GASTROINTESTINAL:
- **Gallbladder Disease** ❑ **Yes** ❑ **No**
- **Liver Disease** ❑ **Yes** ❑ **No**
- **Ulcers** ❑ **Yes** ❑ **No**

GENITOURINARY:
- **Kidney Disease** ❑ **Yes** ❑ **No**
- **Lower Side Pain** ❑ **Yes** ❑ **No**
- **Burning w/urination** ❑ **Yes** ❑ **No**
- **Kidney Stone** ❑ **Yes** ❑ **No**

NEUROLOGICAL:
- **Seizures** ❑ **Yes** ❑ **No**
- **Numbness/Weakness** ❑ **Yes** ❑ **No**
- **Severe/Frequent Headache** ❑ **Yes** ❑ **No**
- **Stroke** ❑ **Yes** ❑ **No**

MUSCULOSKELETAL:
- **Gout** ❑ **Yes** ❑ **No**
- **Arthritis** ❑ **Yes** ❑ **No**
- **Rheumatoid Arthritis** ❑ **Yes** ❑ **No**
- **Joint Stiffness** ❑ **Yes** ❑ **No**
- **Muscle Weakness** ❑ **Yes** ❑ **No**
- **Fibromyalgia** ❑ **Yes** ❑ **No**

ENDOCRINE:
- **Thyroid Disease** ❑ **Yes** ❑ **No**
- **Diabetes** ❑ **Yes** ❑ **No**
- **Dementia** ❑ **Yes** ❑ **No**

HEMATOLOGIC/LYMPHATIC:
- **Hepatitis** ❑ **Yes** ❑ **No**
- **Blood Clots** ❑ **Yes** ❑ **No**
- **Cancer** ❑ **Yes** ❑ **No**
- **Easy Bruising/bleeding** ❑ **Yes** ❑ **No**

ALLERGIC/IMMUNOLOGIC:
- **Hives** ❑ **Yes** ❑ **No**
- **Rash Present** ❑ **Yes** ❑ **No**
- **Immune System Disorder** ❑ **Yes** ❑ **No**
- **MRSA** ❑ **Yes** ❑ **No**

If yes to any of the above please explain: _____

PHYSICIAN USE: ❑ **Reviewed – No Changes** ❑ **Additional Comments:**

_____

Physician Signature: _____ **Date:** _____

Authorization: I hereby authorize the physician to furnish any and all information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original. I hereby acknowledge that I have received a copy of the Orthopedic Center of the Dakotas Notice of Privacy Practices.

_____ _____

Signature **Date**