MIDTOWN ORTHOPEDICS

Patient Information (please print clearly)

IF THIS IS A WORK RELATED OR THIRD PARTY LIABILITY INJURY YOU MUST PROVIDE THE OFFICE WITH ALL OF THE CORRECT INFORMATION BEFORE YOU ARE SEEN **

Patient Legal Name: _____

DOB:____/_____/_____ AGE:_____ Social Security#_____

SEX: Male Female Marital Status: Married Single Divorced Widowed Other

Preferred Language:_____ Need Interpreter: Yes NO

Mailing Address:_____

City:_____ State:_____ ZIP:_____

PHONE:_____ ALTERNATE PHONE:_____ PCP:_____

ALLOWED COMMUNICATION: PHONE____ EMAIL:_____ VOICEMAIL:____ SPOUSE/PARENT_____

Email:_____ REFERRING PHYSICIAN:_____

WORKERS COMP: YES NO **THIRD PARTY LIABILITY:** YES NO **DOI**:_____

PRIMARY INSURANCE:_____ INSUR SUBSCRIBER:_____
POLICY ID#_____ GROUP:_____ EMPLOYER:_____

SUBSCRIBER DOB:_____ SUBSCRIBER SS#:_____

SECONDARY INSURANCE:_____ INSUR SUBSCRIBER:_____

POLICY ID#_____ GROUP:_____ EMPLOYER:_____

SUBSCRIBER DOB:_____ SUBSCRIBER SS#:_____

EMERGENCY CONTACT:_____ PHONE:_____

IT IS THE POLICY OF THIS OFFICE THAT ALL SPECIALIST COPAYS ARE DUE THE DAY OF THE VISIT.

I hereby apply for treatment by the physicians and/or their assistants. I authorize the release of any information necessary to determine liability of payment and/or to obtain reimbursement payment for any claim. I authorize that payment of benefits be made on my behalf and I assign to which I am entitled the benefits payable to Midtown Orthopedics. I understand that I am financially responsible for all charges, whether or not covered or not paid by insurance.

Patient/custodial parent signature:_____ DATE:_____

MIDTOWN ORTHOPEDICS

Dr. Jason Emerson, DO

Daniel O'Donnell, PA-C

THIS INFORMATION IS VERY IMPORTANT AS IT HELPS US TO BETTER SERVE YOU. THANK YOU FOR FULLY COMPLETING THESE FORMS.

NAME:_____ DOB:_____ PCP:_____

MAY WE SEND OUR FINDINGS TO YOUR PCP? YES NO

What are you seeing us for today? (Please circle) LEFT RIGHT

Hip Knee Ankle Leg Foot Shoulder Elbow Wrist Hand Arm Neck Back
Other:_____

Is this due an accident/injury? Work Comp Car accident Home Sports Other:_____

WORK COMP:

DATE OF INJURY:_____ Do you have an attorney? YES NO

Attorney Name:_____ Phone#:_____

If this is due to a Work Comp injury have you filed a claim with your employer? YES NO

If yes, WHEN?_____ Was this claim accepted? YES NO Date:_____

CLAIM NUMBER:_____ If Denied are you appealing claim: YES NO

Work Comp Employer:_____ Phone number:_____

ADJUSTOR NAME:_____ Phone number:_____

AUTO ACCIDENT:

DATE OF ACCIDENT:_____ DO YOU HAVE AN ATTORNEY: YES NO

Attorney Name:_____ Phone:_____

Were you wearing your seatbelt? YES NO Did you lose consciousness? YES NO

Were you the driver? YES NO Did airbags deploy? YES NO

Midtown Orthopedics

Patient Name:_____ DOB:_____

PAST MEDICAL HISTORY

AIDS: YES NO ANEMIA: YES NO ARTHRITIS: YES NO

ASTHMA: YES NO BACK PROBLEMS: YES NO BLEEDING TENDENCY: YES NO

BLOOD CLOTS: YES NO BLOOD TRANSFUSION YES NO BRONCHITIS YES NO

BLADDER PROBLEM: YES NO CANCER: YES NO DIABETES: YES NO

DIPTHERIA YES NO EPILEPSY: YES NO GLAUCOMA YES NO

HEART DISEASE: YES NO HEPATITIS: YES NO HEMORRHOIDS: YES NO

HYPERTENSION: YES NO HIV: YES NO LOW BLOOD PRESSURE: YES

MEASLES: YES NO MIGRAINES: YES NO MUMPS: YES NO

PNEUMONIA: YES NO POLIO: YES NO RHEUMATIC FEVER: YES NO

SCARLET FEVER: YES NO SMALL POX: YES NO STROKE: YES NO

THRYOID DISORDER: YES NO TUBERCULOSIS YES NO VENERAL DISEASE: YES NO

ULCER YES NO WHOOPING COUGH YES NO KIDNEY DISORDER: YES NO

SURGICAL HISTORY: Please include all surgery names and dates

_____
_____
_____
_____
_____

TOBACCO USE: Do you smoke YES NO Do you use smokeless tobacco YES NO

Type: Cigarettes Pipes Cigars Snuff Chew how many packs per day:_____

Are you ready to quit: YES NO Date Quit:_____

ALCOHOL USE: Do you drink alcohol YES NO How often per Week?_____

Do you use illicit drugs: YES NO If so, what kind and duration:_____

MIDTOWN ORHTOPEDICS

PATIENT NAME:_____ DOB:_____

Allergies: _____

NO KNOWN ALLERGIES

Are you allergic to:

TAPE: YES NO IODINE/SHELLFISH: YES NO IVP DYE: YES NO LATEX: YES NO PENICILLIN: YES NO

MEDICATIONS:

ARE YOU RECEIVING PRESCRIPTION NARCOTICS FROM ANOTHER PHYSICAN? YES NO

If so, name of physician:_____

Do you have a pain management medication policy with another physician? YES NO

PAIN ASSESSMENT:

Location of pain (please circle) LEFT RIGHT

ANKLE ARM BACK BUTTOCKS ELBOW FINGER FOOT HAND HIP KNEE TOE WRIST

OTHER_____

SEVERITY OF PAIN:

At rest: 0 1 2 3 4 5 6 7 8 9 10

With activity: 0 1 2 3 4 5 6 7 8 9 10

Describe your pain (circle all that apply)

CONSTANT INTERMITTENT ACHY DULL SHARP STABBING

When did your pain/symptoms start_____

Have you had previous treatment for this complaint? (Example: Surgery, injections, physical therapy, medications)_____

_____

_____

MIDTOWN ORTHOPEDICS

PATIENT NAME:_____ DOB:_____

CURRENT MEDICATIONS: PLEASE LIST ALL MEDICATIONS INCLUDING OVER THE COUNTER THAT YOU ARE CURRENTLY TAKING

MEDICATION:	DOSAGE	FREQUENCY

PATIENT SIGNATURE:_____ DATE:_____

MIDTOWN ORTHOPEDICS

PATIENT NAME:_____ DOB:_____

CIRCLE ANY THAT YOU HAVE HAD IN THE PAST 3 MONTHS OR ARE CURRENTLY EXPERIENCING

CONSTITUTIONAL: FEVER, CHILLS, DIAPHORESIS (SWEATS), FATIGUE

HEENT: VISUAL CHANGES, HEADACHES, DIZZINESS, LOSS OF CONSCIOUSNESS

CARDIOVASCULAR: CHEST PAIN, DYSPNEA ON EXERTION (TROUBLE BREATHING WITH EXERTION)

ORTHOPNEA (TROUBLE BREATHING WHILE LYING FLAT)

RESPIRATORY: COUGH, HEMOPTYSIS (COUGHING BLOOD), SHORTNESS OF BREATH, SMOKING HISTORY

ENDOCRINE: POLYDIPSIA/POLYURIA (DRINK A LOT OF FLUID OR FREQUENT URINATION), SKIN CHANGES, UNEXPECTED WEIGHT CHANGES

HEME-LYMPH: SWOLLEN LYMPH NODES, BLEEDING TENDENCIES, EASILY BRUISED, HISTORY OF DEEP VEIN THROMBOSIS, ON BLOOD THINNERS IF SO SPECIFY:_____

GI: Abdominal pain, flank pain, nausea, vomiting, diarrhea, blood in stool, heart burn

GU: increased frequency or urgency of urination, hematuria (blood in urine),

dysuria (trouble with or painful urination)

SKIN: rash, itching, hives

PSYCH: anxiety, depression