

**PATIENT GENERAL INFORMATION**

Patient name: (First, Middle, Last) \_\_\_\_\_

Preferred name: (optional) \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
month day year

Sex: Male / Female / Unidentified      Marital status: Single / Married / Widowed / Separated / Divorced

Primary address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Secondary address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Cell phone: (\_\_\_\_) \_\_\_\_\_ Home phone: (\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_

E-Mail: \_\_\_\_\_ Preferred contact method: Cell / Home / Work / E-Mail

Would you like to be registered for our Patient Portal to view your medical information? (email required) Yes / No

May we leave a voice message? Yes / No Preferred language: English / Spanish / Other: \_\_\_\_\_

Employment status: Employed / Retired / Unemployed If "Employed", occupation: \_\_\_\_\_

Race / Ethnicity: White / Hispanic / African American / Asian / Native American / Other \_\_\_\_\_

Primary physician: (blank if none) \_\_\_\_\_ Referring physician: (blank if none) \_\_\_\_\_

Emergency contact name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Preferred pharmacy: \_\_\_\_\_ Major crossroads: \_\_\_\_\_

Pharmacy phone #: (optional) (\_\_\_\_) \_\_\_\_\_ Pharmacy address: (optional): \_\_\_\_\_

PRIMARY Insurance Policy holder? Self / Spouse / Child / Other Primary Insurance Company: \_\_\_\_\_

If PRIMARY policy holder is NOT "Self", Holder Name: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

SECONDARY Insurance Policy holder? Self / Spouse / Child / Other Secondary Insurance Company: \_\_\_\_\_

If SECONDARY policy holder is NOT "Self", Holder Name: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is this injury related to an accident? Yes / No If "Yes", Work Related / Auto Accident / Other: \_\_\_\_\_

If "Work Related", Employer: \_\_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Legal action pending for this injury? Yes / No If "Yes", Attorney Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**GUARANTOR** (Person responsible for the non-insurance covered medical expenses. Can not be a minor or incapacitated adult)

Social Security # of Guarantor: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Is Guarantor the patient? Yes / No If "Yes", skip to next section

Guarantor name: (First, Last) \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

List persons authorized to discuss your protected health information with our staff and/or pick up prescriptions, x-rays, lab slips. (optional)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

• I AUTHORIZE AND REQUEST ORTHOARIZONA AND ITS DIVISIONS TO:

- PERFORM DIAGNOSTIC PROCEDURES AND TREATMENTS AS MAY BE NECESSARY FOR PROPER MEDICAL CARE.
- RELEASE MY MEDICAL RECORDS TO ANY OTHER PHYSICIAN OR MEDICAL FACILITIES DIRECTLY INVOLVED IN MY CARE AND FOR THE PURPOSE OF ADMINISTERING CLAIMS AND TO OBTAIN MEDICATION HISTORY FOR THE PURPOSE OF TREATMENT.
- ASSIGN PAYMENT OF MY MEDICAL BENEFITS TO ORTHOARIZONA.

I HAVE BEEN MADE AWARE OF AND UNDERSTAND ORTHOARIZONA'S: NOTICE OF PRIVACY PRACTICES, PATIENT FINANCIAL POLICY, NOTICE TO PATIENTS AND ACO BENEFICIARY NOTICE. THE NOTICE TO PATIENTS DISCLOSES THAT ORTHOARIZONA PROVIDERS HAVE A DIRECT FINANCIAL INTEREST IN SEPARATE DIAGNOSTIC OR TREATMENT AGENCIES OR IN NONROUTINE GOODS OR SERVICES THAT THE PATIENT IS BEING PRESCRIBED AND THAT PRESCRIBED TREATMENTS, GOODS OR SERVICES ARE AVAILABLE ON A COMPETITIVE BASIS. THE ACO BENEFICIARY NOTICE STATES THAT ORTHOPEDIC SPECIALISTS OF NORTH AMERICA, PLLC (ORTHOARIZONA) IS PARTICIPATING IN A MEDICARE SHARED SAVINGS PROGRAM ACCOUNTABLE CARE ORGANIZATION.

PATIENT / PARENT / GUARDIAN SIGNATURE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
month day year

## PATIENT INTAKE & REVIEW OF SYSTEMS

Patient name: (First, Last) \_\_\_\_\_ Occupation: \_\_\_\_\_

Height: \_\_\_ft \_\_\_in Weight: \_\_\_\_\_ lbs Hand dominance: LEFT / RIGHT / AMBIDEXTROUS

Any recent falls? YES / NO If "Yes", were you injured? YES / NO

Did you have a flu shot in past year? YES / NO Did you have a Pneumonia vaccination? YES / NO If "Yes", when \_\_\_\_\_

### INJURY / PAIN / CONCERN - INFORMATION

Body part: \_\_\_\_\_

Side of the body affected: LEFT / RIGHT / BOTH

Reason for visit: \_\_\_\_\_ When did the problem start / date of injury? \_\_\_\_\_ month \_\_\_\_\_ day \_\_\_\_\_ year

How did it happen? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Pain frequency: RARE / SOMETIMES / ALWAYS

Pain scale: (circle) 1 2 3 4 5 6 7 8 9 10  
mild moderate severe

Received previous treatment for this problem? YES / NO If "Yes", Provider: \_\_\_\_\_ Month/Year: \_\_\_\_\_

Circle any type of images or tests you've had for this problem? X-RAYS / CAT SCAN (CT)/ MRI / EMG / LAB WORK / ULTRASOUND

If you had images or tests, which location / facility / company did them: \_\_\_\_\_

Current treatment of problem: BRACING / CANE / CRUTCHES / WALKER / INJECTION / MEDICATION / SURGERY / THERAPY / NONE

List any medications or supplements you are currently taking:

*\*\* if taking more than below, ask the front desk for the medication form*

MEDICATION / SUPPLEMENT	DOSE

List any allergies you may have (medications, food, latex, iodine, nuts, etc) and the reaction to each:

ALLERGIC TO:	REACTION

Pain description: ACHY / BURNING / DULL / SHARP / THROBBING / OTHER \_\_\_\_\_

Associated symptoms: CATCHING / POPPING / LOCKING / GRINDING / SWELLING / STIFFNESS / INSTABILITY / WEAKNESS / TINGLING / NIGHT PAIN / OTHER \_\_\_\_\_

Check only the symptoms that are affecting you TODAY: (\*\*any symptoms left unmarked below will be regarded as negative/not applicable)

#### GENERAL

- Fever
- Chills
- Fatigue
- Sleep problems
- Weight loss

#### EYES

- Blurry vision
- Double vision
- Eye pain
- Eye redness
- Watering

#### EAR, NOSE, THROAT:

- Decreased hearing
- Sore throat
- Ears ringing
- Nose bleeds
- Difficulty swallowing

#### CARDIOVASCULAR

- Chest pain
- Fainting
- Murmurs
- Palpitations

#### RESPIRATORY

- Shortness of breath
- Coughing
- Wheezing
- Tightness
- Snoring

#### GASTROENTEROLOGY

- Heartburn
- Constipation
- Nausea
- Vomiting
- Diarrhea
- Blood/tarry stools

#### GENITOURINARY

- Pain on urination
- Incontinence
- Increased frequency
- Urgency

#### MUSCULOSKELETAL

- Joint pain
- Stiffness
- Joint swelling
- Cramps
- Weakness
- Muscle pain

#### DERMATOLOGY

- Redness
- Rash
- Itching
- Skin changes

#### NEUROLOGY

- Numbness
- Tingling
- Loss of balance
- History of seizure
- Tremors
- Unsteady gait

#### PSYCHOLOGICAL

- Anxiety
- Depression
- Nervousness
- Hallucinations

#### ENDOCRINOLOGY

- Weight change
- Thirsty all the time
- Excessive urination

#### HEMATOLOGY

- Easy bruising
- Easy bleeding
- Enlarged lymph nodes

## PATIENT HEALTH HISTORY

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

**PERSONAL MEDICAL HISTORY - Check all that apply to you (\*\*any items left unmarked below will be regarded as negative/not applicable)**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Alcohol abuse<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Aneurysm<br><input type="checkbox"/> Anxiety<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Back pain<br><input type="checkbox"/> Birth defect<br><input type="checkbox"/> Bladder disease<br><input type="checkbox"/> Bleeding disorder<br><input type="checkbox"/> Blood clots / DVT<br><input type="checkbox"/> Blood pressure – high<br><input type="checkbox"/> Blood pressure – low<br><input type="checkbox"/> Bronchitis<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Cellulitis<br><input type="checkbox"/> Cerebral palsy<br><input type="checkbox"/> Chronic pain | <input type="checkbox"/> Congestive heart failure<br><input type="checkbox"/> COPD<br><input type="checkbox"/> Dementia<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Diabetes – type I<br><input type="checkbox"/> Diabetes – type II<br><input type="checkbox"/> Diverticulitis<br><input type="checkbox"/> Drug abuse<br><input type="checkbox"/> Eczema<br><input type="checkbox"/> Emphysema<br><input type="checkbox"/> End State Renal Disease<br><input type="checkbox"/> Epilepsy / seizures<br><input type="checkbox"/> Esophageal reflux<br><input type="checkbox"/> Fibromyalgia<br><input type="checkbox"/> Fracture / broken bone<br><input type="checkbox"/> Gastric ulcers<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Gout | <input type="checkbox"/> Hay fever<br><input type="checkbox"/> Heart attack<br><input type="checkbox"/> Heart disease<br><input type="checkbox"/> Heart valve disease<br><input type="checkbox"/> Hepatitis / jaundice<br><input type="checkbox"/> Hiatal hernia<br><input type="checkbox"/> High cholesterol<br><input type="checkbox"/> Kidney disease<br><input type="checkbox"/> Kidney stones<br><input type="checkbox"/> Leukemia<br><input type="checkbox"/> Liver disease<br><input type="checkbox"/> Migraine headaches<br><input type="checkbox"/> MRSA<br><input type="checkbox"/> Multiple sclerosis<br><input type="checkbox"/> Osteoarthritis<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Pancreatitis<br><input type="checkbox"/> Pneumonia | <input type="checkbox"/> Prostrate disorder<br><input type="checkbox"/> Psychiatric illness<br><input type="checkbox"/> Pulmonary embolism<br><input type="checkbox"/> Rheumatoid arthritis<br><input type="checkbox"/> Scoliosis<br><input type="checkbox"/> Seizure disorder<br><input type="checkbox"/> Sickle cell<br><input type="checkbox"/> Sleep apnea – CPAP<br><input type="checkbox"/> Sleep apnea – no CPAP<br><input type="checkbox"/> Stomach disease / ulcers<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Thyroid disease<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Valley fever<br><input type="checkbox"/> Vascular disease<br><input type="checkbox"/> Wound healing<br>Other:<br><input type="checkbox"/> _____ |
|--|---|---|--|

**SURGICAL HISTORY - Check all that apply to you and indicate the Month & Year of the surgery**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Adenoidectomy Mo/Yr: _____<br><input type="checkbox"/> Amputation Mo/Yr: _____<br><input type="checkbox"/> Appendectomy Mo/Yr: _____<br><input type="checkbox"/> Bladder surgery Mo/Yr: _____<br><input type="checkbox"/> Brain tumor Mo/Yr: _____<br><input type="checkbox"/> Cancer Mo/Yr: _____<br><input type="checkbox"/> Cataracts Mo/Yr: _____<br><input type="checkbox"/> Craniotomy Mo/Yr: _____<br><input type="checkbox"/> C-Section Mo/Yr: _____<br><input type="checkbox"/> Gallbladder Mo/Yr: _____ | <input type="checkbox"/> Gastric bypass Mo/Yr: _____<br><input type="checkbox"/> Heart – bypass Mo/Yr: _____<br><input type="checkbox"/> Heart – carotid Mo/Yr: _____<br><input type="checkbox"/> Heart – pacemaker Mo/Yr: _____<br><input type="checkbox"/> Heart – stent Mo/Yr: _____<br><input type="checkbox"/> Heart - valve Mo/Yr: _____<br><input type="checkbox"/> Hernia repair Mo/Yr: _____<br><input type="checkbox"/> Hysterectomy Mo/Yr: _____<br><input type="checkbox"/> Lung resection Mo/Yr: _____<br><input type="checkbox"/> Mastectomy Mo/Yr: _____ | <input type="checkbox"/> Prostate surgery Mo/Yr: _____<br><input type="checkbox"/> Sinus surgery Mo/Yr: _____<br><input type="checkbox"/> Thyroid surgery Mo/Yr: _____<br><input type="checkbox"/> Tonsillectomy Mo/Yr: _____<br><input type="checkbox"/> Tubal ligation Mo/Yr: _____<br><input type="checkbox"/> Vasectomy Mo/Yr: _____<br><input type="checkbox"/> Vision correction Mo/Yr: _____<br>Other:<br><input type="checkbox"/> _____ Mo/Yr: _____<br><input type="checkbox"/> _____ Mo/Yr: _____ |
|--|---|---|
- |   |  |
|---|--|
| <input type="checkbox"/> Knee: Left / Right / Total Joint Mo/Yr: _____<br><input type="checkbox"/> Ankle: Left / Right / Total Joint Mo/Yr: _____<br><input type="checkbox"/> Hip: Left / Right / Total Joint Mo/Yr: _____<br><input type="checkbox"/> Elbow: Left / Right / Total Joint Mo/Yr: _____ | <input type="checkbox"/> Shoulder: Left / Right / Total Joint Mo/Yr: _____<br><input type="checkbox"/> Hand: Left / Right Mo/Yr: _____<br><input type="checkbox"/> Spine: Cervical / Thoracic / Lumbar Mo/Yr: _____<br><input type="checkbox"/> Other Orthopedic Surgery / Procedure: _____ Mo/Yr: _____ |
|---|--|

**FAMILY MEDICAL HISTORY**

**Do you know your family history?** YES / NO / ADOPTED

**As best as possible, check all that apply to your IMMEDIATE FAMILY and circle who in your family has the checked condition**

- |   |  |
|---|--|
| <input type="checkbox"/> Anesthesia complications Mom / Dad / Siblings / Kids<br><input type="checkbox"/> Asthma Mom / Dad / Siblings / Kids<br><input type="checkbox"/> Arthritis – Rheumatoid Mom / Dad / Siblings / Kids<br><input type="checkbox"/> Arthritis – Osteoarthritis Mom / Dad / Siblings / Kids<br><input type="checkbox"/> Arthritis - Osteoporosis Mom / Dad / Siblings / Kids<br><input type="checkbox"/> Bleeding disorder Mom / Dad / Siblings / Kids<br><input type="checkbox"/> Cancer Mom / Dad / Siblings / Kids<br><input type="checkbox"/> Coronary heart disease Mom / Dad / Siblings / Kids | <input type="checkbox"/> Deep Vein Thrombosis (DVT) Mom / Dad / Siblings / Kids<br><input type="checkbox"/> Diabetes Mom / Dad / Siblings / Kids<br><input type="checkbox"/> Hemophilia Mom / Dad / Siblings / Kids<br><input type="checkbox"/> Hypertension Mom / Dad / Siblings / Kids<br><input type="checkbox"/> Kidney disease Mom / Dad / Siblings / Kids<br><input type="checkbox"/> Pulmonary embolism Mom / Dad / Siblings / Kids<br><input type="checkbox"/> Seizures Mom / Dad / Siblings / Kids<br><input type="checkbox"/> Stroke Mom / Dad / Siblings / Kids |
|---|--|

**Ever have complications during surgery?** YES / NO    **Ever have complications with anesthesia?** YES / NO

**Do you smoke tobacco?** YES / NO / QUIT    **If “Yes”, # of packs per week** \_\_\_\_\_ **If “Quit”, year quit** \_\_\_\_\_ & **# of packs per week** \_\_\_\_\_

**Do you chew tobacco?** YES / NO / QUIT    **If “Yes”, # of times per week** \_\_\_\_\_ **If “Quit”, year quit** \_\_\_\_\_ & **# of times per week** \_\_\_\_\_

**Do you drink alcohol?** YES / NO    **If “Yes”, # drinks per week** \_\_\_\_\_    **Do you exercise regularly?** YES / NO

**Do you use medical marijuana?** YES / NO    **Do you use recreational drugs?** YES / NO    **If “Yes”, what drug(s)** \_\_\_\_\_

**Marital status:** SINGLE / MARRIED / WIDOWED / SEPARATED / DIVORCED    **Work type:** PHYSICAL / SEDENTARY (SEATED)

**Work status:** RETIRED / STAY AT HOME / REGULAR DUTY / LIGHT DUTY / OUT OF WORK    **Do you live alone?** YES / NO