OrthoArizona

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, HAD THE OPPORTUNITY TO REVIEW, REQUEST A HARD COPY IF DESIRED, 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. COPY AVAILABLE UPON REQUEST OR AT ORTHOARIZONA.ORG.

PATIENT / PARENT / GUARDIAN SIGNATURE: _____ **TODAY'S DATE:** _____/_____/_____ (month / day / year)

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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 (mild) 2 3 4 5 (moderate) 6 7 8 9 10 (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

ENDOCINOLOGY
- □ Weight change
- □ Thirsty all the time
- □ Excessive urination

HEMATOLOGY
- □ Easy bruising
- □ Easy bleeding
- □ Enlarged lymph nodes

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First Name: _____

Last Name: _____

PATIENT HEALTH HISTORY

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

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

Other:

- ☐ _____

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

- ☐ Adenoidectomy *Mo/Yr*: _____
- ☐ Amputation *Mo/Yr*: _____
- ☐ Appendectomy *Mo/Yr*: _____
- ☐ Bladder surgery *Mo/Yr*: _____
- ☐ Brain tumor *Mo/Yr*: _____
- ☐ Cancer *Mo/Yr*: _____
- ☐ Cataracts *Mo/Yr*: _____
- ☐ Craniotomy *Mo/Yr*: _____
- ☐ C-Section *Mo/Yr*: _____
- ☐ Gallbladder *Mo/Yr*: _____
- ☐ Gastric bypass *Mo/Yr*: _____
- ☐ Heart – bypass *Mo/Yr*: _____
- ☐ Heart – carotid *Mo/Yr*: _____
- ☐ Heart – pacemaker *Mo/Yr*: _____
- ☐ Heart – stent *Mo/Yr*: _____
- ☐ Heart - valve *Mo/Yr*: _____
- ☐ Hernia repair *Mo/Yr*: _____
- ☐ Hysterectomy *Mo/Yr*: _____
- ☐ Lung resection *Mo/Yr*: _____
- ☐ Mastectomy *Mo/Yr*: _____
- ☐ Prostate surgery *Mo/Yr*: _____
- ☐ Sinus surgery *Mo/Yr*: _____
- ☐ Thyroid surgery *Mo/Yr*: _____
- ☐ Tonsillectomy *Mo/Yr*: _____
- ☐ Tubal ligation *Mo/Yr*: _____
- ☐ Vasectomy *Mo/Yr*: _____
- ☐ Vision correction *Mo/Yr*: _____

Other:

- ☐ _____ *Mo/Yr*: _____
- ☐ _____ *Mo/Yr*: _____

- ☐ Knee: Left / Right / Total Joint *Mo/Yr*: _____
- ☐ Ankle: Left / Right / Total Joint *Mo/Yr*: _____
- ☐ Hip: Left / Right / Total Joint *Mo/Yr*: _____
- ☐ Elbow: Left / Right / Total Joint *Mo/Yr*: _____
- ☐ Shoulder: Left / Right / Total Joint *Mo/Yr*: _____
- ☐ Hand: Left / Right *Mo/Yr*: _____
- ☐ Spine: Cervical / Thoracic / Lumbar *Mo/Yr*: _____
- ☐ 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

- ☐ Anesthesia complications Mom / Dad / Siblings / Kids
- ☐ Asthma Mom / Dad / Siblings / Kids
- ☐ Arthritis – Rheumatoid Mom / Dad / Siblings / Kids
- ☐ Arthritis – Osteoarthritis Mom / Dad / Siblings / Kids
- ☐ Arthritis - Osteoporosis Mom / Dad / Siblings / Kids
- ☐ Bleeding disorder Mom / Dad / Siblings / Kids
- ☐ Cancer Mom / Dad / Siblings / Kids
- ☐ Coronary heart disease Mom / Dad / Siblings / Kids
- ☐ Deep Vein Thrombosis (DVT) Mom / Dad / Siblings / Kids
- ☐ Diabetes Mom / Dad / Siblings / Kids
- ☐ Hemophilia Mom / Dad / Siblings / Kids
- ☐ Hypertension Mom / Dad / Siblings / Kids
- ☐ Kidney disease Mom / Dad / Siblings / Kids
- ☐ Pulmonary embolism Mom / Dad / Siblings / Kids
- ☐ Seizures Mom / Dad / Siblings / Kids
- ☐ 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