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 / Caucasian / 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:** _____ **SSN #** ____-____-____

**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)

**Same as 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)

*Rev 050418*

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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)

**Pain description:** ACHY / BURNING / DULL / SHARP / THROBBING / OTHER_____

**Associated symptoms:** CATCHING / POPPING / LOCKING / GRINDING / SWELLING / STIFFNESS / INSTABILITY / WEAKNESS / TINGLING / NIGHT PAIN / OTHER_____

**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

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**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

**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 |
|---|---|
| | |
| | |
| | |
| | |
| | |

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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
- ☐ Facture / broken bone
- ☐ Gastric ulcers
- ☐ Glaucoma
- ☐ Gout
- ☐ Hay fever
- ☐ Heart disease
- ☐ Heart valve disease
- ☐ Hepatitis / jaundice
- ☐ Hiatal hernia
- ☐ 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 / Total Joint *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