

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: _____ **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

PATIENT INTAKE

Patient name: (First, Last) _____

Occupation: _____

Height: ___ft ___in Weight: _____ lbs Hand dominance: LEFT / RIGHT / AMBIDEXTROUS

Do you have diabetes? YES / NO If "Yes", type _____

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

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

List any medications or supplements you are currently taking:

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

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

MEDICATION / SUPPLEMENT	DOSE

ALLERGIC TO:	REACTION