SPARTAN ORTHOPEDIC INSTITUTE

Who referred you to Spartan Orthopedic Institute? _____

Patient Information:

Last Name: _____ First Name: _____ MI: _____ ☐ Male ☐ Female

Mailing Address: _____ City: _____ State: _____ Zip: _____

Street Address: _____ City: _____ State: _____ Zip: _____

E-Mail Address: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Social Security #: _____ Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer Name: _____ Work Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____

Person Responsible for Bill:

Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____

Insurance Information:

Primary Insurance Company: _____ Telephone #: _____

Policy Number: _____ Group Number: _____

Insured's Name: _____ Date of Birth: _____ Relation to Patient: _____

****

Secondary Insurance Company: _____ Telephone #: _____

Policy Number: _____ Group Number: _____

Insured's Name: _____ Date of Birth: _____ Relation to Patient: _____

Authorization and Release:

I authorize the release of all medical information necessary to process this claim and is pertinent to my medical care. I authorize and request my insurance company to pay directly to Orthonorthrup/SOI insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered.

_____ _____

Patient/Guarantor Signature **Date**

NEW PATIENT HISTORY FORM

Patient Information

Vital Signs: Height: Height Weight: Weight

Race ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other

Preferred Language ☐ English ☐ Spanish ☐ Chinese ☐ Other

Preferred Pharmacy PUBLIX PHARMACY #1239

Referral Source:

Physician: (ex. Dr. John Doe)

Other: (ex. Google Search, Friend, Other Patient)

Chief Complaint

Dominant Hand:

☐ Right hand ☐ Left Hand

Description Of The Symptoms (select only one)

☐ Pain ☐ Numbness/Tingling ☐ Fracture ☐ Stiffness Other:

Shoulder	☐ Right ☐ Left	Pelvis	☐ Right ☐ Left	Neck	☐
Upper Arm	☐ Right ☐ Left	Hip	☐ Right ☐ Left	Upper Back	☐
Elbow	☐ Right ☐ Left	Thigh	☐ Right ☐ Left	Mid Back	☐
Forearm	☐ Right ☐ Left	Knee	☐ Right ☐ Left	Low Back	☐
Wrist	☐ Right ☐ Left	Lower Leg	☐ Right ☐ Left	Buttocks	☐
Hand	☐ Right ☐ Left	Ankle	☐ Right ☐ Left	Tail Bone	☐
Thumb	☐ Right ☐ Left	Foot	☐ Right ☐ Left		
Index	☐ Right ☐ Left	Great Toe	☐ Right ☐ Left		
Middle	☐ Right ☐ Left	2nd Digit	☐ Right ☐ Left		
Ring	☐ Right ☐ Left	3rd Digit	☐ Right ☐ Left		
Little	☐ Right ☐ Left	4th Digit	☐ Right ☐ Left		
		5th Digit	☐ Right ☐ Left		

History Of Present Illness

1. Is Your Problem The Result Of An Injury Or Accident?

☐ No injury ☐ Injury ☐ Injury at Work ☐ Auto Accident ☐ Sport Injury ☐ Prior Surgery

2. Are You Represented By An Attorney? ☐ Yes ☐ No

3. Have You Had A Problem Like This Before? ☐ Yes ☐ No

4. Have You Been Seen In ER For This Problem? ☐ Yes ☐ No

5. Rate The Pain (10 Being The Most Pain).

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

6. Do The Symptoms Wake You From Sleep? ☐ Yes ☐ No

7. Please Describe The Symptoms.

☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Shooting

8. What Is The Timing Of The Symptoms?

☐ Constant ☐ Intermittent (comes & goes)

9. Is The Problem Getting Better Or Worse?

☐ Getting better ☐ Getting worse ☐ Unchanged

10. What Makes The Symptoms Worse?

☐ Squatting ☐ Kneeling ☐ Sitting ☐ Bending ☐ Stairs ☐ Twisting ☐ Moving ☐ Lying in Bed

☐ Running ☐ Walking ☐ Athletics ☐ Standing ☐ Gripping ☐ Lifting ☐ Reaching Overhead

11. Are There Any Other Symptoms Associated To This Problem:

☐ Redness ☐ Bruising ☐ Swelling ☐ Numbness ☐ Stiffness ☐ Limping ☐ Clicking ☐ Locking

☐ Popping ☐ Tingling ☐ Weakness ☐ Giving way ☐ Grinding ☐ Instability/Slipping

12. Does your Condition interfere with any of the following

☐ Daily Activities ☐ School Activities ☐ Work Activities ☐ Recreation or Sports Activities

Staff Enter History (Please Type Full Sentences)

Prior Treatment / Testing

Have You Had Any Prior Tests For This Problem?

☐ None ☐ X-rays (Where:) ☐ MRI(Where:) ☐ CAT Scan (Where:) ☐ Nerve Test (EMG) (Where:) ☐ Bone Scan (Where:)

Have You Had Any Prior Treatments For This Problem? ☐ Yes ☐ No

Health History Of Patient

No For All ☐

	Yes	No		Yes	No		Yes	No
Heart Trouble	☐	☐	Kidney Stones	☐	☐	Phlebitis	☐	☐
Diabetes	☐	☐	Bleeding Disorders	☐	☐	Anemia	☐	☐
Gout	☐	☐	Alcholism	☐	☐	Stomach Ulcers	☐	☐
Seizures	☐	☐	Serious Injuries	☐	☐	Liver Trouble	☐	☐
Mental Illness	☐	☐	Lung Disease	☐	☐	Thyroid Trouble	☐	☐
Kidney Trouble	☐	☐	Tuberculosis	☐	☐	Other Illnesses	☐	☐

Medical Questions

Mark All That Currently Apply:

☐ Metal in body ☐ Claustrophobic ☐ Pregnant ☐ Sleep Apnea ☐ Use a C PAP ☐ Snores

Are you taking blood thinners? ☐ Yes ☐ No

FAMILY HISTORY

Have any direct relatives had any of the following disorders? ☐ None for all

Father:

☐ None ☐ Diabetes ☐ Heart Disease ☐ Hypertension
☐ Bleeding Problems ☐ Epilepsy ☐ Connective Tissue ☐ Muscular Dystrophy
☐ Stroke ☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Cancer

Comments:

Mother:

☐ None ☐ Diabetes ☐ Heart Disease ☐ Hypertension
☐ Bleeding Problems ☐ Epilepsy ☐ Connective Tissue ☐ Muscular Dystrophy
☐ Stroke ☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Cancer

Comments:

Sibling:

☐ None ☐ Diabetes ☐ Heart Disease ☐ Hypertension
☐ Bleeding Problems ☐ Epilepsy ☐ Connective Tissue ☐ Muscular Dystrophy
☐ Stroke ☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Cancer

Comments:

SOCIAL HISTORY

1. Do You Smoke Or Chew Tobacco? ☐ Daily ☐ Occasionally ☐ Former user ☐ Never How Many Years Smoked? (Packs per day?)

2. Do You Drink Alcohol? ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

3. Marital History: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership

4. Are You Currently Working? ☐ Yes ☐ No ☐ Retired ☐ Disabled

Occupation: Employer: ☐ Student | Where:

Enter All Below Information Into The Medical Information Tab

Do You Have Any Allergies? Yes ☐ No ☐

Medication, Foods, Seasonal Or Metal : ☐ NONE

Please List All Medications You Take On A Regualr Basis: ☐ NONE

Do You Have A Personal History Of Any Of The Following? ☐ NONE

☐ Aneurysm - Where:	☐ Emphysema	☐ Kidney Disease
☐ Angina (chest pain)	☐ Epilepsy	☐ Kidney Stones
☐ Arthritis - Type:	☐ Heart Attack	☐ MRSA Infection
☐ Asthma	☐ Hepatitis - Type:	☐ Pacemaker
☐ Bone or Joint Infections	☐ HIV/AIDS	☐ Phlebitis (Blood Clots)
☐ Cancer - Type:	☐ High Cholesterol	☐ Pulmonary Embolism
☐ Chemotherapy/Radiation	☐ Hypertension	☐ Reaction to Anesthesia - Type:
☐ COPD	☐ Hyperthyroidism	☐ Stomach Ulcers<
☐ Congestive Heart Failure	☐ Hypothyroidism	☐ Stroke / TIA
☐ Diabetes - Type:	Last A1C	☐ Tuberculosis

Other:

Review Of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months? ☐ None for all

				Comments NONE
1) GI	☐ Heartburn, Ulcers	☐ Nausea, Vomiting	☐ Blood in Stool	☐
2) ENDO	☐ Fever	☐ Heat or Cold Intolerance	☐ Night Sweats	☐
3) CON	☐ Weight Loss	☐ Loss of Appetite	☐ Fatigue	☐
4) EYE	☐ Blurred Vision	☐ Double Vision	☐ Vision Loss	☐
5) ENT	☐ Hearing Loss	☐ Hoarseness	☐ Trouble Swallowing	☐
6) CARDIO	☐ Chest Pain	☐ Palpitations		☐
7) LUNGS	☐ Chronic Cough	☐ Pneumonia	☐ Shortness of Breath	☐
8) GU	☐ Painful Urination	☐ Blood in Urine	☐ Kidney Problems	☐
9) SKIN	☐ Frequent Rashes	☐ Skin Ulcers	☐ Lumps ☐ Psoriasis	☐
10) NEURO	☐ Frequent Falls	☐ Loss of Coordination	☐ Numbness	☐
	☐ Change in bowel	☐ Change in bladder	☐ Dizziness	
11) PSYCH	☐ Depression/Anxiety	☐ Drug/Alcohol Addiction	☐ Sleep Disorder	☐
12) HEM	☐ Easy Bleeding	☐ Easy Bruising	☐ Anemia	☐