Date:_____

PREFIX:_____ NAME:_____
FIRST MI LAST

DOB:_____ SOCIAL SECURTIY #:_____ MARITAL STATUS: M S D W SEX: M

MAILING ADDRESS:_____
CITY STATE ZIP

HOME PHONE:_____WORK#_____ CELL#_____

PREFERRED CONTACT# HOME WORK CELL **Is it OK to leave message at this number? YES NO**

Is today's visit due to an auto accident? YES NO Date of Injury:_____

Is today's visit due to a work related injury? YES NO Date of Injury:_____

Employer:_____Phone#:_____Occupation:_____

Employer's Address:_____
CITY STATE ZIP

Primary Insurance:_____ ID#_____ Group#_____

Subscriber:_____ DOB:_____/_____/_____ Relationship to Patient:_____

Secondary Insurance:_____ ID#_____ Group#_____

Subscriber:_____ DOB:_____/_____/_____ Relationship to Patient:_____

Pharmacy:_____ Phone#:_____ Address:_____

Prescription Coverage if Different from Insurance: _____

Primary care Physician:_____ Phone#:_____

Address:_____
CITY STATE ZIP

E-MAIL ADDRESS:_____

How Did You Hear About Our Practice: Newspaper Internet Insurance Co. Word Of Mouth (family/friend) Jordan Hospital

RACE: (PLEASE CIRCLE)

American Indian/Alaskan Native
Asian
Native Hawaiian
White
Black
Hispanic
Other Race
Other Pacific Islander
Unreported/Refused to Report

ETHNICITY (PLEASE CIRCLE)

Central American
Cuban
Dominican
Hispanic
Latin American/Latin/Latino
Non-Hispanic or Latino
Puerto Rican
South American
Spaniard

LANGUAGE

English
Spanish
Other:_____

DO YOU HAVE A HEALTH CARE PROXY ? YES NO HAS THIS BEEN PROVIDED TO US ? NO

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATI

I authorize Plymouth Bay Orthopedic Associates, Inc. (PBO)to furnish information acquired in the course of this examination or treatment to my insurance company for the purpose of payment.
I, hereby assign to Plymouth bay Orthopedic Associates, Inc., all payments for medical services rendered to me and or my dependents.

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that this assignment does not lessen my financial responsibility. I agree to be responsible for any payment of any and all unpaid services/charges rendered on behalf of myself or my dependents, including any fees for collection services. Plymouth Bay Orthopedic Associates, Inc., reserves the right to request payment at the time services are rendered.

PRESCRIPTION HISTORY CONSENT

I authorize Plymouth Bay Orthopedic Associates, Inc., to obtain a history of my prescriptions during the course of medical care rendered by any provider at Plymouth Bay Orthopedic Associates, Inc.

ACKNOWLEDGEMENT RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have read the Notice of Privacy Practices and have been offered a copy.

I have read, understand and agree to all of the above listed information.

_____

Signature of Patient Date

The patient is an unemancipated minor or is unable to sign for the following reasons:

_____

therefore I am signing on their behalf.

_____

Name Relationship Date

MEDICAL HISTORY

Reason for Today's Visit:_____

Questions You Would Like Answered Today:_____

List All Medications You Are Currently Taking Including Name & Dose of Medication:

1. _____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____

Please indicate if you have ever had any of the following:

Diagnosis:

___High Blood Pressure
___Heart Disease/Attack
___High Cholesterol
___Stroke/CVA
___Ulcers
___Reflux
___Emphysema
___Breathing Problems/COPD
__Asthma
___Anemia
___Clotting/Bleeding Problems
___DVT/Blood Clots/Phlebitis
___Arthritis/Joint Pain
___Osteoporosis
___Fractures/Broken Bones
___Gout
___Thyroid Disease
___Hepatitis
___HIV Disease
___Tuberculosis
___Depression
___Anxiety
___Kidney Disease/Urinary Issues
___Diabetes
___Cancer, Type_____

Symptoms:

___Unplanned Weight Loss
___Fevers
___Headaches
___Dizziness/Fainting
___Chest Pain
___Swelling of Arms/Legs
___Blurred Vision
___Hearing Loss
___Problems with Anesthesia

Other Disease or Problems Not Listed:_____ _____

_____

_____

Are You Allergic To Any medications or Latex? YES NO If Yes, please list

1._____ 2._____ 3._____
4._____ 5._____ 6._____

List All Surgeries You have had with an approximate date:_____

1._____ 2._____ 3._____
4._____ 5._____ 6._____

Have you ever been hospitalized for anything other the surgery? YES NO If yes, please list:_____

Reason: Date:

_____

_____

Has anyone in your family had any of the following?_____

____Heart Disease ____Diabetes ____Stroke ____High Blood Pressure ____Tuberculosis
____Clotting/Bleeding Problems ____High Cholesterol ____Problems with Anesthesia ____Cancer, Type_____

Are you **RIGHT** or **LEFT** handed? (Please circle one) What is your occupation?_____

Do you smoke? **YES** **NO** If yes, how much and for how long?_____ Are you interested in quitting? **YES** **NO**

Do you drink alcohol? **YES** **NO** If yes, how often and what is the amount?_____

Activities? (Hobbies or Sports) _____

I believe this information is true and complete to the best of my knowledge:

_____ _____
Patient Signature Date

Physician Notes:

_____

_____

_____