PHILADELPHIA ORTHOPAEDIC ASSOCIATES

DATE:______________________________

NAME:____
(LAST) (FIRST) (M.I.)

STREET ADDRESS;____

CITY:____STATE_____________________________ZIP CODE________________

HOME PHONE #:_____________________________________WORK PHONE #____

CELL PHONE #____

SOCIAL SECURITY #_________________________________MARITIAL STATUS_____________________________________

DATE OF BIRTH:_________________________AGE:___________________SEX:_________

PARENT'S NAME (IF MINOR)____

PHONE NUMBER:____

PATIENT'S EMPLOYER:____

EMPLOYER'S ADDRESS:____

____

____

OCCUPATION:____HOW LONG EMPLOYED:______________________________

REASON FOR VISIT

IF AN INJURY, IS IT A RESULT OF: ☐ AUTO ACCIDENT ☐ WORK ☐ OTHER_____________________

PART OF BODY TO BE TREATED: ☐ RIGHT ☐ LEFT____

EXPLAIN REASON VISIT____

___ ____

DATE OF ACCIDENT/SYMPTOMS:____________________________________

SEEN IN EMERGENCY ROOM?_____________________WHERE?____

X-RAY_________YES _________NO IF YES, WHERE?____

FAMILY/REFERRING FAMILY PHYSICIAN:____PHONE #:__________________

ADDRESS:____

ARE YOU ALLERGIC TO ANY MEDICATIONS? (PLEASE LIST)____

PRESENT MEDICATIONS:____

____

____

ATTORNEY INFORMATION

NAME:____PHONE NO.____________________

ADDRESS:____ZIP __________

GENERAL MEDICAL INFORMATION

PREVIOUS OR OTHER MEDICAL PROBLEMS:____

LIST ANY PREVIOUS SURGERIES OR HOSPITALIZATIONS (INCLUDE NUMBER OF MISCARRIAGES AND LIVE BIRTHS):_____

____

____

LIST ANY PREVIOUS SURGERIES OR HOSPITALIZATIONS (INCLUDE NUMBER OF MISCARRIAGES AND LIVE BIRTHS):______

____

____

DO YOU SMOKE: ☐YES ☐NO ☐CIGARETTES ☐ PIPE ☐ CIGARS NO OF YRS.____ HOW MUCH?________

INTERESTED IN STOPPING?__________

DO YOU REGULARLY DRINK ALCOHOL? ☐ YES ☐ NO HOW MANY OUNCES / BEERS PER DAY? _______________

DO YOU DRINK COFFEE ☐YES ☐ NO HOW MANY CUPS PER DAY?____________________________

PERSONAL MEDICAL HISTORY

HAVE YOU HAD ANY OF THE FOLLOWING:

☐ CHEST PAIN / PRESSURE / TIGHTENING	☐ ASTHMA	☐ KIDNEY DISEASE
☐ HYPERTENSION	☐ DIZZY SPELLS	☐ SHORTNESS OF BREATH
☐HEART ATTACK	☐ CANCER	☐ TB/ LUNG DISORDER
☐ STROKE	☐ DIABETES	☐ ULCERS
☐ HEADACHES	☐ ARTHRITIS	☐ SKIN DISORDERS
☐ ECZEMA	☐ DIFFICULTY HEARING	☐ HEPATITIS
☐ ALLERGIES	☐ GLAUCOMA	☐CATARACTS
☐ DEPRESSION	☐ MEMORY LOSS	☐ DIGESTIVE PROBLEMS
☐ BLOOD IN STOOL	☐ HEMORRHOIDS	☐ FREQUENT URINARY INFECTIONS

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

I HEREBY AUTHORIZE DR. ____

TO RELEASE TO YOUR COMPANY OR ITS REPRESENTATIVE, ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD OF SUCH MEDICAL OR SURGICAL CARE. I UNDERSTAND I AM RESPONSIBLE TO THE DOCTOR FOR CHARGES NOT COVERED BY INSURANCE AND BY SIGNING, ACCEPT SAME AS IRREVOCABLE.

I ALSO AUTHORIZE AND REQUEST YOUR COMPANY TO PAY DIRECTLY TO THE ABOVE NAMED DOCTOR THE AMOUNT DUE ME IN MY PENDING CLAIM FOR BASIC MEDICAL, MAJOR MEDICAL AND / OR SURGICAL TREATMENT OF SERVICES, BY REASON OF SUCH TREATMENT OR SERVICES RENDERED TO:

____

PATIENT

DATE:______________________________SIGNATURE____

PARENT , PATIENT OR GUARDIAN