

PATIENT INSURANCE INFORMATION

PATIENT'S NAME _____ DATE OF BIRTH _____

ADDRESS _____

_____ MARITAL STATUS _____

HOME # _____ WORK# _____ CELL# _____

EMPLOYER NAME & ADDRESS _____

OCCUPATION _____ SOCIAL SECURITY # _____

REFERRED BY _____ PERSON TO CONTACT IN CASE OF AN

EMERGENCY _____ PHONE # _____

HEALTH INSURANCE:

PRIMARY INSURANCE CO. _____

ID# _____ GROUP # _____

SUBSCRIBER NAME _____ DOB _____

SECONDARY INSURANCE CO. _____

ID# _____ GROUP# _____

SUBSCRIBER NAME _____ DOB _____

WERE YOU INJURED ON THE JOB? _____ **DATE OF INJURY** _____

WORKER'S COMPENSATION INFORMATION:

EMPLOYER'S INSURANCE CARRIER NAME/ADDRESS _____

_____ CLAIM/CASE # _____

WERE YOU INJURED IN A **CAR ACCIDENT?** _____ **DATE** _____

NO-FAULT INSURANCE:

CARRIER NAME/ADDRESS _____

HAVE YOU **MISSED ANY WORK?** _____ **DATES MISSED** _____

INSURANCE AUTHORIZATION/WAIVER

I hereby authorize Burdett Orthopedics, PC to release my medical records to my insurance company concerning my illness and treatment. In addition, in the event that I have not provided Burdett Orthopedics, PC with the correct insurance information and/or have not obtained a managed care referral authorizing my treatment, I understand that I am financially responsible for any charges for such treatment.

DATE _____ **SIGNATURE** _____

IF MINOR, PARENT OR LEGAL GUARDIAN _____

PATIENT MEDICAL HISTORY FORM

PATIENT'S NAME _____ SEX ____ AGE ____ DOB _____

PRIMARY MD _____ DATE OF INJURY _____

DID YOU HAVE X-RAYS/MRI FOR THIS? _____ OTHER TESTING? _____
WHERE WERE THEY DONE? _____ DO YOU HAVE THEM WITH YOU? _____

HAVE YOU SEEN ANY OTHER SPECIALISTS FOR THIS PROBLEM? _____ WHO? _____

WHAT **ORTHOPEDIC CONDITION** WARRANTS YOUR VISIT TODAY? _____

LIST ALL MEDICATIONS (INCLUDING PAIN MEDICATIONS), SUPPLEMENTS, VITAMINS, HORMONES AND NUTRITIONAL AIDS THAT YOU TAKE INCLUDING OVER THE COUNTER MEDICINES: 1) _____ 2) _____

3) _____ 4) _____ 5) _____

LIST ALL MEDICAL CONDITIONS (EXAMPLE: HIGH BLOOD PRESSURE, DIABETES, ETC) YOU ARE BEING TREATED FOR AND REASONS FOR ANY MEDICINES THAT YOU TAKE:

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

LIST ALL MEDICATION ALLERGIES YOU HAVE: NONE 1) _____

2) _____ 3) _____ 4) _____

LIST ALL SURGERIES YOU HAVE HAD & APPROXIMATELY WHEN THEY WERE PERFORMED: 1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

ALCOHOL USE _____ TOBACCO USE (CURRENT & PAST) _____

ARE YOU **LEFT HANDED OR RIGHT HANDED?** LEFT RIGHT

DO YOU USE A **CANE, BRACE OR ANY OTHER ORTHOPEDIC/AMBULATORY AIDS?** _____

DO YOU HAVE ANY **METALLIC IMPLANTS IN YOUR BODY?** (PACEMAKER, HEART VALVE, METAL FRAGMENTS) _____

RECENT ILLNESS OR HEALTH STATUS CHANGE _____

ANY OF THE FOLLOWING SYMPTOMS? CIRCLE ALL THAT APPLY.

FEVER/CHILLS

NASAL CONGESTION, SNEEZING, SORE THROAT, HEADACHE

NAUSEA, VOMITING, DIARRHEA, ABDOMINAL PAIN, HEART BURN

CHEST PAIN, COUGH, SHORTNESS OF BREATH

FREQUENT URINATION OR BURNING

DEPRESSION, ANXIETY, NERVOUSNESS

SIGNATURE

DATE