DESERT REGIONAL MEDICAL CENTER
Institute of Clinical Orthopedics & Neurosciences

## PATIENT'S INFORMATION

| NAME (Last, First, Middle) | | | PREVIOUS LAST NAME | NICKNAME |
|---|---|---|---|---|
| SSN | BIRTHDATE | SEX | DRIVER'S LICENSE NUMBER | STATE ISSUED |

## PATIENT'S BILLING/MAILING ADDRESS

| STREET OR PO BOX | | |
|---|---|---|
| CITY | STATE | ZIP |
| COUNTRY<br>☐ USA<br>☐ OTHER __________ | COUNTY | |

## PATIENT'S PHYSICAL ADDRESS

| STREET ADDRESS | | |
|---|---|---|
| CITY | STATE | ZIP |
| COUNTRY<br>☐ USA<br>☐ OTHER __________ | COUNTY | |

## PATIENT'S EMERGENCY CONTACT INFORMATION

| NAME | ADDRESS | RELATIONSHIP | CONTACT PHONE NUMBER |
|---|---|---|---|

## PATIENT'S ADDITIONAL INFORMATION

| MOTHER'S MAIDEN NAME | RACE<br>☐ ASIAN ☐ PACIFIC ISLANDER<br>☐ BLACK ☐ UNKNOWN<br>☐ NATIVE AMERICAN ☐ WHITE<br>☐ OTHER | LANGUAGE<br>☐ ENGLISH<br>☐ SPANISH<br>☐ OTHER __________ | RELIGION<br>CHURCH | |
|---|---|---|---|---|
| ETHNICITY<br>☐ HISPANIC<br>☐ NON-HISPANIC<br>☐ UNKNOWN | MARITAL STATUS<br>☐ ANNULLED ☐ POLYGAMOUS<br>☐ DIVORCED ☐ SINGLE<br>☐ INTERLOCUTORY ☐ WIDOWED<br>☐ LEGALLY SEPERATED<br>☐ LIFE PARTNER ☐ UNKNOWN<br>☐ MARRIED | STUDENT STATUS<br>☐ FULL-TIME<br>☐ NOT A STUDENT<br>☐ PART-TIME | VETRAN | SMOKER |

| HOME PHONE NUMBER |
|---|
| DAY PHONE NUMBER |
| ALTERNATE PHONE NUMBER |
| E-MAIL ADDRESS |
| CELL PHONE NUMBER |

## PRIMARY CARE PROVIDER/PHYSICIAN

| NAME | |
|---|---|
| STREET ADDRESS | |
| CITY, STATE, AND ZIP | |
| OFFICE PHONE NUMBER | FAX NUMBER |

## RESPONSIBLE PARTY'S INFORMATION (if different than above)

| NAME (Last, First, Middle) | | | PREVIOUS LAST NAME | NICKNAME |
|---|---|---|---|---|
| SSN | BIRTHDATE | SEX | RELATIONSHIP TO PATIENT | |

## RESPONSIBLE PARTY'S BILLING/MAILING ADDRESS

| STREET OR PO BOX | | |
|---|---|---|
| CITY | STATE | ZIP |

## RESPONISBLE PARTY'PHYSICAL ADDRESS

| STREET ADDRESS | | |
|---|---|---|
| CITY | STATE | ZIP |

| HOME PHONE NUMBER | E-MAIL ADDRESS |
|---|---|
| DAY PHONE NUMBER | CELL PHONE NUMBER |
| ALTERNATE PHONE NUMBER | |

## PATIENT'S EMPLOYER

| NAME OF EMPLOYER | ☐ LOCAL ADDRESS<br>☐ CORPORATE ADDRESS |
|---|---|
| EMPLOYER'S ADDRESS (Street, City, State and Zip) | COUNTY |
| TYPE OF BUSINESS | OCCUPATION |
| EMPLOYEMENT STATUS<br>☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ DISABLED | WORK PHONE |

REV. 04/18/2012

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| PRIMARY INSURANCE | | | |
|---|---|---|---|
| NAME OF SUBSCRIBER (Last, First, Middle) | RELATIONSHIP TO PATIENT | | |
| SUBSCRIBER'S ADDRESS (Street, City, State and Zip) | | POLICY NUMBER | |
| SUBSCRIBER'S SOCIAL SECURITY NUMBER | | SUBSCRIBER'S DATE OF BIRTH | |
| NAME OF INSURANCE COMPANY | | GROUP NUMBER | |
| ADDRESS OF INSURANCE COMPANY (Street, City, State, and Zip) | | EFFECTIVE DATE | EXPIRATION DATE |

| SECONDARY INSURANCE (if applicable) | | | |
|---|---|---|---|
| NAME OF SUBSCRIBER (Last, First, Middle) | RELATIONSHIP TO PATIENT | | |
| SUBSCRIBER'S ADDRESS (Street, City, State and Zip) | | POLICY NUMBER | |
| SUBSCRIBER'S SOCIAL SECURITY NUMBER | | SUBSCRIBER'S DATE OF BIRTH | |
| NAME OF INSURANCE COMPANY | | GROUP NUMBER | |
| ADDRESS OF INSURANCE COMPANY (Street, City, State, and Zip) | | EFFECTIVE DATE | EXPIRATION DATE |

## ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with ________________________________________ and assign directly to Dr. _______________________ all medical benefits. **I understand that I am financially responsible for all charges incurred. A copy of the back and front of my insurance card is required for billing purposes.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions. Sometimes healthcare information may be used for research, all such information is anonymous, and patient confidentiality is maintained. If you do not want any information to be used for research please check here ______.

**Signature of Insured** ______________________________________________________________ **Date** _____________________________

## CONSENT FOR TREATMENT

I, the undersigned hereby authorize and give consent to Dr. ________________________ for any x-rays examinations, laboratory tests, and treatment rendered to the patient named above.

**Signature** _______________________________________________________________________ **Date** _____________________________

## MEDICARE AUTHORIZATION

I request the payment of authorized Medicare benefits be made directly to me or the physician rendering services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

**Signature** ________________________________________________________________________ **Date** ____________________________

***Please be advised, it is the patient's responsibility to ensure that the physician they see is contracted with their insurance plan.***

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## PATIENT'S INFORMATION

| NAME (Last, First, Middle) | BIRTHDATE |
|---|---|
| PREFERRED PHARMACY (Name, Address, Phone Number) | |
| BACKUP PHARMACY (Name, Address, Phone Number) | |

## REASON FOR VISIT

| | | |
|---|---|---|
| □ Ankle □ Back □ Clavicle □ Calf □ Elbow □ Foot<br>□ Hand □ Heel □ Hip □ Knee □ Lower Leg □ Shoulder<br>□ Upper Arm □ Lower Arm □ Other ______________ | □ Right<br>□ Left<br>□ Bilateral | □ Fracture<br>□ Pain<br>□ Swelling |
| □ Ankle □ Back □ Clavicle □ Calf □ Elbow □ Foot<br>□ Hand □ Heel □ Hip □ Knee □ Lower Leg □ Shoulder<br>□ Upper Arm □ Lower Arm □ Other ______________ | □ Right<br>□ Left<br>□ Bilateral | □ Fracture<br>□ Pain<br>□ Swelling |
| □ Ankle □ Back □ Clavicle □ Calf □ Elbow □ Foot<br>□ Hand □ Heel □ Hip □ Knee □ Lower Leg □ Shoulder<br>□ Upper Arm □ Lower Arm □ Other ______________ | □ Right<br>□ Left<br>□ Bilateral | □ Fracture<br>□ Pain<br>□ Swelling |
| □ Ankle □ Back □ Clavicle □ Calf □ Elbow □ Foot<br>□ Hand □ Heel □ Hip □ Knee □ Lower Leg □ Shoulder<br>□ Upper Arm □ Lower Arm □ Other ______________ | □ Right<br>□ Left<br>□ Bilateral | □ Fracture<br>□ Pain<br>□ Swelling |
| □ Ankle □ Back □ Clavicle □ Calf □ Elbow □ Foot<br>□ Hand □ Heel □ Hip □ Knee □ Lower Leg □ Shoulder<br>□ Upper Arm □ Lower Arm □ Other ______________ | □ Right<br>□ Left<br>□ Bilateral | □ Fracture<br>□ Pain<br>□ Swelling |
| □ Ankle □ Back □ Clavicle □ Calf □ Elbow □ Foot<br>□ Hand □ Heel □ Hip □ Knee □ Lower Leg □ Shoulder<br>□ Upper Arm □ Lower Arm □ Other ______________ | □ Right<br>□ Left<br>□ Bilateral | □ Fracture<br>□ Pain<br>□ Swelling |

## ALLERGIES (Medication(s), Environmental Issue(s), and Food(s))

| Item(s) that you are *allergic* to: | Reaction(s) you have had from the *Allergen*, you are allergic to: |
|---|---|
| | |
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## MEDICATIONS AND SUPPLEMENTS THAT YOU TAKE ON REGULAR BASIS

| Drug Name (Brand name, or generic name) | Dosage | Times taken within 24 Hours | Reason for taking Medication |
|---|---|---|---|
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## PRESENT ILLNESS

| | | | |
|---|---|---|---|
| Onset:<br>□ Gradual<br>□ Sudden | Treatment Date:<br>______________ | Status:<br>□ Resolved □ Improving<br>□ Stable □ Worsening | Pain Frequency:<br>□ Persistence □ Occasional<br>□ Intermittent □ Rare |
| Cause:<br>□ Injury<br>□ Motor Vehicle Accident<br>□ Sports Injury<br>Type of Sport ____________<br>□ No Injury | Type of Injury:<br>□ Bending □ Direct Blow<br>□ Exercising □ Fall<br>□ Jumping □ Lifting<br>□ Other<br>______________ | Where Injured:<br>□ At home<br>□ At school<br>□ At work<br>□ Other<br>______________ | Date of Injury:<br>______________ |

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## PATIENT INFORMATION

| NAME (Last, First, Middle) | BIRTHDATE |
|---|---|
| | |

## REVIEW OF SYSTEMS

**CONSTITUTIONAL:**

| No | Yes | | No | Yes | |
|---|---|---|---|---|---|
| ☐ | ☐ | Chills | ☐ | ☐ | Weight Gain |
| ☐ | ☐ | Fatigue | ☐ | ☐ | Weight Loss |
| ☐ | ☐ | Fever | | | |
| ☐ | ☐ | Malaise | | | |
| ☐ | ☐ | Night Sweats | | | |
| ☐ | ☐ | Weakness | | | |

**METABOLIC/ENDOCRINE:**

| No | Yes | |
|---|---|---|
| ☐ | ☐ | Cold Intolerant |
| ☐ | ☐ | Hair Loss |
| ☐ | ☐ | Heat Intolerant |

**HEAD, EYES, EARS, NOSE, AND THROAT:**

| No | Yes | |
|---|---|---|
| ☐ | ☐ | Blurred Vision |
| ☐ | ☐ | Double Vision |
| ☐ | ☐ | Dysphagia (difficulty swallowing) |
| ☐ | ☐ | Ear Drainage |
| ☐ | ☐ | Facial Pain |
| ☐ | ☐ | Headache |
| ☐ | ☐ | Hearing Loss |
| ☐ | ☐ | Hoarseness |
| ☐ | ☐ | Nasal Congestion |
| ☐ | ☐ | Ringing in the Ears |
| ☐ | ☐ | Vertigo (dizziness) |
| ☐ | ☐ | Vision Loss |

**NEUROLOGICAL:**

| No | Yes | |
|---|---|---|
| ☐ | ☐ | Difficulty Walking |
| ☐ | ☐ | Dizziness |
| ☐ | ☐ | Poor Coordination |
| ☐ | ☐ | Memory Loss |
| ☐ | ☐ | Muscle Weakness |
| ☐ | ☐ | Parathesia (Numbness/Tingling of Skin) |
| ☐ | ☐ | Seizures |
| ☐ | ☐ | Tremors |

**RESPIRATORY:**

| No | Yes | |
|---|---|---|
| ☐ | ☐ | Chest Pain related to Respiratory Problems |
| ☐ | ☐ | Cough |
| ☐ | ☐ | Dyspnea (Shortness of breath) |
| ☐ | ☐ | Recent Respiratory Infections |
| ☐ | ☐ | Known TB Exposure |
| ☐ | ☐ | Wheezing |

**PSYCHIATRIC:**

| No | Yes | |
|---|---|---|
| ☐ | ☐ | Anxiety |
| ☐ | ☐ | Depression |
| ☐ | ☐ | Insomnia |

**CARDIOVASCULAR:**

| No | Yes | |
|---|---|---|
| ☐ | ☐ | Chest Pain related to Cardiac Problems |
| ☐ | ☐ | Cyanosis (Blue or Purple Coloration of Skin) |
| ☐ | ☐ | Heart Murmur |
| ☐ | ☐ | Leg Swelling |
| ☐ | ☐ | Syncope (Fainting) |
| ☐ | ☐ | Irregular Heartbeat/Palpitations |

**INTEGUMENTARY (SKIN):**

| No | Yes | |
|---|---|---|
| ☐ | ☐ | Contact Allergy |
| ☐ | ☐ | Itchy Skin |
| ☐ | ☐ | Rash |
| ☐ | ☐ | Skin Infections |
| ☐ | ☐ | Skin Lesion |

**GASTROINTESTINAL:**

| No | Yes | |
|---|---|---|
| ☐ | ☐ | Abdominal Pain |
| ☐ | ☐ | Constipation |
| ☐ | ☐ | Black Tarry Stools |
| ☐ | ☐ | Diarrhea |
| ☐ | ☐ | Juandice |
| ☐ | ☐ | Loss of Appetite |
| ☐ | ☐ | Nausea |
| ☐ | ☐ | Vomitting |

**HEMATOLOGIC:**

| No | Yes | |
|---|---|---|
| ☐ | ☐ | Bleeding |
| ☐ | ☐ | Bruising |

**GENITOURINARY**

| No | Yes | | No | Yes | |
|---|---|---|---|---|---|
| ☐ | ☐ | Dysuria (Painful Urination) | ☐ | ☐ | Urge Incontinence |
| ☐ | ☐ | Frequent Urination | ☐ | ☐ | Urinary Incontinence |
| ☐ | ☐ | Hematuria | | | |

**OTHER CONDITIONS NOT NOTED:**

____________________________________________________________

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| CHRONIC PROBLEM LIST | | PAST SURGICAL HISTORY | |
|---|---|---|---|
| Chronic Problem | Onset Date | Procedure | Year |
| | | | |
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## FAMILY HISTORY (Please List only Mother, Father, Brother, and Sister)

□ PATIENT ADOPTED □ NO RELEVANT FAMILY HISTORY

| Diagnosis | Family Member | Name | Age Onset or Age Death | Comments |
|---|---|---|---|---|
| | | | | |
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## SOCIAL HISTORY

Hand Dominance

□ Right □ Left □ Ambidextrous

Height: ____________________

Weight: ____________________

Occupation: ________________

Marital Status: _______________

Activity Level

□ Moderate □ Sedentary □ Vigorous

Type of Exercise(s)

________________________________________________

________________________________________________

Exercise Frequency

□ 2-3 Times/Week □ 3-4 Times/Week □ Daily

□ Never □ Occasional

Hours/Week

□ 0 □ 1-5 □ 5-10

□ 11-15 □ 16-20 □ > 20

Tobacco Use

Uses Tobacco: □ Currently □ Formerly
□ Never □ Unknown

Type: □ Chewing □ Cigar □ Cigarettes
□ Pipe □ Smokeless □ Snuff

Units/Day: ________

Years Used: ________

Alcohol Use:

□ Yes □ No

□ Formerly - Year Quit ____________

If "YES" –

Type of Alcohol ________________________________________

Amount ____________________________________________

Frequency __________________________________________

When was Last Drink ______________________________

Caffeine Use:

□ Yes □ No

Type ______________________________________________

Amount Daily ________________________________________

________________________________ ________________________________ ________________________________

Patient's Printed Name Patient's Signature Date Signed