

NEW PATIENT INFORMATION FORM

Alvarado Orthopaedic Medical Group, Inc.

Last, First Name _____ Home Phone: _____

Address: _____ Work Phone: _____

City/State/Zip: _____ Cell Phone: _____

SSN: _____ Marital Status: _____ Sex: _____ Birthdate: ___ / ___ / ___

Email: _____ Driver's License: _____ State: _____

Emergency Contact Name/Phone/Relation: _____

Patient Employer: _____ Phone: _____

City/State/Zip: _____ Job Title: _____

Referring Doctor/Patient: _____ Phone : _____

Address/City/State/Zip: _____

How did you hear about us ? _____

PRIMARY INSURANCE COVERAGE

Please show ID Card to Secretary for a copy

Insurance Company: _____ Phone: _____

Policy ID: _____ Group #: _____

Address/City/Zip: _____

Parent or Guardian Information

If Patient is under 18 years of age

Signature to authorize treatment and follow-up: _____

Last, First Name: _____ SSN: _____

Address: _____ Phone: _____

City/State/Zip: _____ Work Phone: _____

Driver's License: _____ State: _____ Cell Phone: _____

Employer: _____ Title: _____

Address/City/State/Zip: _____

The preceding information is true to the best of my knowledge

TREATMENT/PAYMENT AGREEMENT FOR ALVARADO ORTHOPEDIC MEDICAL GROUP, INC.

I authorize release of any medical or other information necessary to process claims and for payment of assigned medical benefits for my medical services to Alvarado Orthopaedic Medical Group, Inc. I agree that I am ultimately responsible for my account regardless of insurance coverage. I understand that my personal medical insurance will not be billed, if my injuries were a result of an auto accident, work injury, or other liable accident. I acknowledge that finance charges will be added to accounts unpaid after 90 days at 1% per month and that I will be responsible for collection and legal costs involved in collections. Should AOMG consider it appropriate to assign my account to a collection agency, an additional charge of 10% to the principal obligation will be added.

Signature: _____

Date: _____

NEW PATIENT INFORMATION FORM

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Last/First Name: _____ Nickname: _____
 Age: _____ Height: _____ Weight: _____ RIGHT or LEFT handed (circle)
 Primary Physician: _____

History of Present Illness, Injury or Complaint

Reason for Visit: _____
 Date of onset or injury _____
 Treatments to date: _____
 Is this work related ? (circle) YES / NO If YES, date last worked: _____
 Related to a motor vehicle accident: (circle): YES / NO
 Is there any litigation (Lawsuit) involved: YES / NO

PAST MEDICAL HISTORY

Please list your medical problems, diagnoses, and previous injuries with approximate dates:

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

PAST SURGICAL HISTORY:

Please list any surgical procedures and approximate dates:

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

MEDICATIONS

Please list all current medications and frequently used over the counter medications. Include dosage and frequency.

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

ALLERGIES:

Please list any allergies and briefly describe the reaction:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

SOCIAL HISTORY:

Do You use tobacco ? YES / NO # of years _____, packs per day _____
 If you quit, when ? _____
 Do you use alcohol? YES / NO How much / how often ? _____
 Describe any other drug of substance use: _____

FAMILY HISTORY:

Please list major medical problems in your family and the individual affected:

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

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Have you ever been diagnosed by a physician with any of the following:

	YES	NO		YES	NO
ABNORMAL CHEST XRAY	_____	_____	HEART ATTACK	_____	_____
ABNORMAL EKG	_____	_____	HEART MURMUR	_____	_____
ALCOHOLISM	_____	_____	HEMORRHOIDS	_____	_____
ANGINA	_____	_____	HEPATITIS B, C	_____	_____
ANXIETY/PANIC ATTACKS	_____	_____	HIATAL HERNIA	_____	_____
ANEMIA	_____	_____	HIGH BLOOD PRESSURE	_____	_____
ASTHMA	_____	_____	KIDNEY TROUBLE	_____	_____
BLEEDING DISORDER	_____	_____	MIGRAINE HEADACHES	_____	_____
BLINDNESS	_____	_____	OSTEOARTHRITIS	_____	_____
BOWEL PROBLEMS	_____	_____	PHLEBITIS/BLOOD CLOTS	_____	_____
CANCER	_____	_____	POLIO	_____	_____
CHRONIC BRONCHITIS	_____	_____	PROSTATE PROBLEMS	_____	_____
DEPRESSION	_____	_____	RHEUMATIC FEVER	_____	_____
DRUG ADDICTION	_____	_____	RHEUMATOID ARTHRITIS	_____	_____
EMPHYSEMA	_____	_____	STROKE	_____	_____
EPILEPSY / SEIZURES	_____	_____	THYROID DISORDER	_____	_____
FIBROMYALGIA	_____	_____	TUBERCULOSIS	_____	_____
GALLSTONES	_____	_____	ULCER	_____	_____
GLAUCOMA	_____	_____	VERICOSE VEINS	_____	_____
CATARACTS	_____	_____	VENEREAL DISEASE	_____	_____
GOUT	_____	_____			
HARD OF HEARING	_____	_____	OTHER (Write In) _____		

Do you have any of the following:

BACK PAIN	_____	_____	MEMORY LOSS	_____	_____
CHEST PAIN	_____	_____	PAINFUL JOINTS	_____	_____
CHILLS	_____	_____	SHORTNESS OF BREATH	_____	_____
DIFFICULTY WITH BALANCE	_____	_____	SWOLLEN ANKLES	_____	_____
FEVER	_____	_____	SWOLLEN JOINTS	_____	_____
INDIGESTION	_____	_____	WEAKNESS IN ARMS	_____	_____
IRREGULAR HEARTBEAT	_____	_____	WEAKNESS IN LEGS	_____	_____
LEG CRAMPS	_____	_____			

Do you use:

BRACE OR PROSTHESIS	_____	_____
CONTACT LENSES	_____	_____
DENTURES	_____	_____
GLASSES	_____	_____
HEARING AIDES	_____	_____

Do you have:

CLAUSTROPHOBIA	_____	_____
METAL IN YOUR BODY	_____	_____
PACEMAKER	_____	_____

Date of last tetanus shot: _____

Number of pregnancies: _____

Do you have children? (Names / Ages)

1. _____
2. _____
3. _____
4. _____

5. _____
6. _____
7. _____
8. _____

SIGNATURE OF PATIENT: _____

Date: ____ / ____ / ____

SIGNATURE OF PARENT/GUARDIAN AUTHORIZING TREATMENT OF MINOR: _____