

TRI-STATE ORTHOPAEDICS PHYSICIANS, PLC
2800 PIERCE ST., SUITE 101 • SIOUX CITY, IOWA 51104 • 712-224-8677

**PATIENT
PERSONAL INFORMATION**
(please print)

| |
|---|
| For office use only: Account # _____ EX _____ Date of appt. _____ Time _____ |
|---|

Patient's legal name _____ Home Phone (____) _____
Last First legal Middle Cell Phone (____) _____

Patient's Address _____
RR, Box #, Street Address City State Zip

Sex ____ Birthdate _____ Age ____ Race _____ Patient's S.S. # _____

Marital Status: S M D W Student: Full Time Part Time

Patient's Employer & Address _____
Work Phone (____) _____ Ext. _____

Spouse's Name _____ Work Number (____) _____ Ext. _____

Spouse's Employer & Address _____

Spouse's DOB _____ Spouse's S.S. # _____

Parent's Names & Address _____

If minor, list BOTH parents) Mother's Work # (____) _____ Father's Work # (____) _____

Name of friend or nearest relative not living at your address _____

Address _____
RR, Box #, Street Address City State Zip

Relationship _____ Home Phone (____) _____ Work Phone (____) _____

INSURANCE INFORMATION

Was this an on the job injury? Yes No If yes, _____ (date of injury) and please complete the following:

Name & address of employer **at the time** of the accident _____

Workers Comp. Insurance Co., Name & Address _____
Claim Number _____

If this was not an on the job injury, please complete the following:

Primary Insurance _____
Name Address

Policy Holder's Employer & Address _____

Policy Holder _____ Relationship to patient _____

Policy Holder's S.S. # _____ DOB _____ Policy No. _____ Group No. _____

Secondary Insurance _____
Name Address

Policy Holder's Employer & Address _____

Policy Holder _____ Relationship to patient _____

Policy Holder's S.S. # _____ DOB _____ Policy No. _____ Group No. _____

Third Insurance _____
Name Address

Policy Holder _____ Relationship to patient _____

Policy Holder's S.S. # _____ DOB _____ Policy No. _____ Group No. _____

Are you being represented by an attorney? Yes No

If yes, name and address of attorney _____

I hereby authorize Tri-State Orthopaedic Physicians, PLC to release any information acquired in the course of my examination and treatment to the insurance company. This authorization is valid for the type of coverage I have reported to Tri-State Orthopaedic Physicians, PLC, coverages to include group, private, auto, homeowners, Medicare or Medicaid. This authorization permits release of any and all information EXCEPT substance abuse (drug or alcohol), mental health and AIDS-related information which must be specifically authorized by a separate form. If this is a work comp claim, the authorization extends to my employer, work comp insurance, adjuster, rehabilitation specialist or representative of my employer.

I permit a copy of this authorization to be used in place of the original. I also authorize the insurance company to make payment of the surgical and/or medical benefits directly to Tri-State Orthopaedic Physicians, PLC.

Signed _____ Date _____

Today's Date _____

Patient Information

First Name: _____ Last: _____ Age: ____ Sex: ____ Wt: ____ Ht: ____ R or L Handed

Employer: _____ Occupation: _____ Years ____ Circle: Nonmanual Light Heavy Manual

If a student, what school are you attending: _____ Grade: _____

Family Dr. or Internist: _____ How were you referred to us? _____
(i.e., Doctor, Self, Advertisement, Friend, Family, Phone Book)

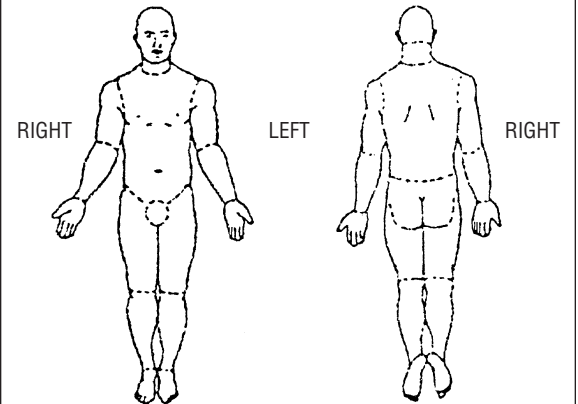
Please provide us some brief information on your current illness or injury:

1. Chief complaint for this visit: _____
2. Date of injury or onset: _____
3. Location of Accident: _____ Not an accident
(i.e., home, public building, work, friends home, car accident, etc....)
4. Frequency of symptoms: _____
5. Describe your symptoms: _____
(i.e., stabbing, dull, sharp, tingling)
6. What makes it worse: _____
7. What makes it better: _____
8. Other body parts affected: _____
(i.e., radiating pain)
9. Are you working? Yes No
 If No, are you off due to your injury? Yes No
10. Last date worked _____
11. If you are working, please list any restrictions: _____

Please mark down any previous treatments you may have received for this injury or illness:

| | Yes | No | Who | When |
|-------------------|-----|----|-----|------|
| Self Treatment: | | | | |
| Family Dr: | | | | |
| Shots: | | | | |
| Chiropractor: | | | | |
| X-Ray: | | | | |
| MRI: | | | | |
| CT Scan: | | | | |
| Arthrogram: | | | | |
| Myelogram: | | | | |
| Bone Scan: | | | | |
| EMG: | | | | |
| Blood Work: | | | | |
| Epidural Flood: | | | | |
| Facet Injections: | | | | |
| Biopsy: | | | | |
| Other: | | | | |

DIAGRAM (MARK THE PARTS OF YOUR BODY WHERE YOUR PAIN IS USING THE SYMBOLS INDICATED BELOW)



| | | | |
|----------|--|--------------------------------|--|
| ACHE | | PINS/NEEDLES | |
| STABBING | | POPPING, CRACKING, OR GRINDING | |
| SWELLING | | | |
| NUMBNESS | | | |

Please circle the severity of your pain: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Are you ALLERGIC or Sensitive to any medications? Yes No

If so, please list: _____

MEDICATIONS (list any you are taking and dosage)

See Reverse Side

MD's Initials: _____ Page 2

Past Medical History:

Please list any medical problems: _____

Have you had any anesthesia problems in the past? Yes No If yes, please explain below:

Please list your surgeries and hospitalizations with dates: (Please check if extra space needed and use back of page one)

Social History:

- I. Do you smoke? Yes No How much do you smoke daily? _____
- II. Have you ever smoked? Yes No How much did you used to smoke? _____ When quit? _____
- III. Current Marital Status: S M D W
- IV. How often do you drink alcohol? _____ Amount _____
- V. How many children do you have? _____

Family Medical History:

- I. Are your parents still living? Mother Yes No Age at death: _____ Cause: _____
Father Yes No Age at death: _____ Cause: _____

II. Please list anyone in your **immediate** family who have any of the below conditions: (mother father, brother, sister)
Who Who

| | |
|----------------------------|--------------------------------------|
| High Blood Pressure: _____ | Heart Disease: _____ |
| Diabetes: _____ | Cancer: _____ |
| Anesthesia Problems: _____ | Seizures: _____ |
| Migraines: _____ | Strokes: _____ |
| Alzheimer's _____ | Tremors: _____ |
| Multiple Sclerosis: _____ | Arthritis (rheumatoid, osteo): _____ |

Review of Systems: (Have you ever had any of the following?)

- | | | | |
|--|--|--|--|
| Constitutional | Respiratory | Hematology/Lymphatic | Musculoskeletal |
| Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No | TB <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Prev. Back/Neck Prob. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ears, Nose, Mouth, Throat Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Broken Bones <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiovascular | Psychological Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Gastrointestinal | Metal Implants <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Clots <input type="checkbox"/> Yes <input type="checkbox"/> No | Endocrine | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No | Integumentary |
| Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Bowel Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurologic |
| High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergy | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizure/Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Anesthesia Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Genitourinary | Head Injury <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No | Infection/MRSA <input type="checkbox"/> Yes <input type="checkbox"/> No | Bladder Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Sexual Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | |

All other medical problems: _____

Please complete this part ONLY if you are a school athlete:

Sport(s): _____ Position(s) _____
School: _____ Coach: _____

May we send a copy of your medical records to your: Coach Yes No Athletic Trainer Yes No

Please be advised that by signing this you authorize the physicians of Tri-State Orthopaedic Physicians, PLC to release all medical records (or my child's) to my family physician, requesting physician, and to any facility in which further testings or surgeries may be performed.

Signed: _____ Date _____

(Patient unless a minor)

MD's Initials: _____ Page 3