Starkville ORTHOPEDIC CLINIC

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PATIENT INFORMATION

Patient Name____

Last First MI

Mailing Address____

Address City State Zip

Physical Address____

Address City State Zip

Social Security #______________________ Date of Birth______________

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced Gender: ☐Male ☐Female

Home Phone______________________ Cell Phone______________

Email Address____

Employer______________________ Occupation______________

Employer Address______________________ Work Phone______________

EMERGENCY CONTACT (someone outside your home)

Name______________ Relationship__________ Phone Number__________

GUARANTOR INFORMATION

Guarantor Name______________________ Relationship______________

Mailing Address____

Address City State Zip

Physical Address____

Address City State Zip

Social Security #______________________ Date of Birth______________

Employer______________________ Work Phone______________

INSURANCE INFORMATION (copy of card must be provided)

Insurance______________________ Policy #______________

Policy Holder Name ____

Policy Holder SS#______________________ Policy Holder Date of Birth______________

I authorize medical treatment by Starkville Orthopedic Clinic. I assign all insurance payments to Starkville Orthopedic Clinic. I understand that any unpaid portion of charges for treatment not paid by my insurance company is my responsibility. I understand that if my balance is not paid in a timely manner and the account is referred for outside collections, I am responsible for any processing fees and/or court costs.

______________________ ______________________

Signature (Guardian if patient is minor) Date

Patient Name____ **Date of Birth**____________________________

FAMILY DOCTOR______________________________ **REFERRING DOCTOR**_____________________

CHIEF COMPLAINT____

Is your problem the result of an injury? YES NO If yes, date of injury__________________________

Where did the injury occur? **Work** **Home** **Auto** **Other** (explain)______________________________

Is your pain (please circle) **CONSTANT** or **INTERMITTENT** (comes and goes)

Do any of the following make your pain worse?

☐Prolonged Walking	☐Prolonged Sitting	☐Prolonged Standing	☐Stooping
☐Bending	☐Pushing/Pulling	☐Up/Down Steps	☐Lying Down
☐Grasping	☐Lifting	☐Flexion	☐Extension
☐Any Weight-bearing	☐Any Use of_________________________________		

Changes in symptoms over time? ☐ **Same** ☐ **Better** ☐ **Worse**

Have you had any previous or similar symptoms?(please circle) **YES** or **NO**

If YES, please describe:____

Have you had past treatment for this current problem?(please circle) **YES** or **NO**

Treating Physician_________________________________ **Treatment**________________________________

Injections:	☐YES	☐NO	☐Helped	☐Did NOT help
Aspirations:	☐YES	☐NO	☐Helped	☐Did NOT help
Physical Therapy:	☐YES	☐NO	☐Helped	☐Did NOT help

X-rays/MRI/Other: Date______________ **Where**____________________ **Body Part**__________________

Are you taking any medications? ☐ **YES** ☐ **NO** **Pharmacy**___________________________

(list any medications you are taking including herbal remedies or supplements)

____ ____

____ ____

____ ____

ALLERGIES? ☐ **YES** ☐ **NO** If YES, please list:____

____

Signature____ **Date**____________________________

MEDICAL HISTORY

Patient Name____ **Date of Birth**____________________________

List all of your PAST medical/surgical history below:

- Past Medical History (i.e. diabetes, high blood pressure, etc.) _______________________________________

  ____

- Past Surgical History____

  ____

- Has anyone in your family every had the following:

  ☐Heart Disease ☐Thyroid Disease ☐Tuberculosis ☐Diabetes
  ☐Hypertension ☐Lung Disease ☐Arthritis ☐Cancer
  ☐Asthma ☐None ☐Other____

- Tobacco: ☐YES ☐NO If yes, how many packs per day____________ # of Years______________
- Alcohol: ☐YES ☐NO ____amount/frequency
- Work History:

  Employer________________________________ # of Years_____________ ☐Retired
  Occupation____

If you experience any of the following please check the box beside it (explain any necessary).
☐I have **NOT** experienced any of the conditions listed below.

Constitutional ☐Fever ☐Chills ☐Easy fatigability ☐Sleep problems ☐Weight loss/gain

Musculoskeletal ☐Night cramps ☐Migratory or referred symptoms ☐Joint pain ☐Weakness
☐Stiffness ☐Instability ☐Other____

Vision ☐Visual difficulties ☐Corrective lenses ☐Color blindness ☐Other____________

Ears/Nose/Throat ☐Hearing deficit ☐Smelling deficit ☐Tasting deficit ☐Nosebleeds
☐Mouth sores ☐Dentures ☐Other______________________________

Cardiovascular ☐Chest pain ☐Irregular or fast heartbeat ☐Phlebitis ☐Hypertension

Respiratory ☐Shortness of breath ☐Cough ☐Sputum ☐Spitting up blood ☐Bronchitis

Gastrointestinal ☐Difficulty swallowing ☐Nausea ☐Vomiting ☐Abdominal pain
☐Inability to control bowel movements ☐Jaundice ☐Constipation
☐Change in bowel habits ☐Other____

Genitourinary ☐Change in urinary habits ☐Inability to control urination ☐Kidney Stones

Integumentary ☐Excessive moist/dry skin ☐Itching ☐Rashes ☐Increased bruising

Neurological ☐Headaches ☐Loss of consciousness ☐Dizziness ☐Seizures
☐Paralysis ☐Gait disorder ☐Other_______________

Psychiatric ☐Depression ☐Anxiety ☐Nervous breakdowns ☐Fears
☐Mood Swings ☐Hallucinations ☐Sleep disorders

Endocrine ☐Stature ☐Body configuration ☐Heat/cold intolerance
☐Excessive eating ☐Excessive thirst ☐Excessive urination
☐Other_______________

Hematologic/Lymphatic ☐Free bleeding ☐Anemia ☐Palpable or painful lymph nodes

Allergic/Immunologic ☐Dermatitis ☐Eczema ☐Asthma ☐Seasonal allergies
☐Food allergies ☐Other_______________

I verify that the above information is true and accurate to the best of my knowledge.

_______________________________ _______________________________
Signature (Guardian if minor) Date