



Today's Date \_\_\_\_\_

**WELCOME! Please fill out the following information as thoroughly as possible. ALL INFORMATION IS CONFIDENTIAL.**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

Home Ph \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Gender \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Dominant Hand: **R / L** Marital Status: \_\_\_\_\_

Employer/Occupation \_\_\_\_\_ Email\* \_\_\_\_\_

*\*If provided, email will enable you to enroll in your Personal Health Record*

Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Language \_\_\_\_\_

Body part you are being seen for today? \_\_\_\_\_ **R/L** \_\_\_\_\_

**IF PATIENT IS UNDER 18, please provide guardian information (and copy of DRIVERS LICENSE):**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ SS# \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Number(s) \_\_\_\_\_ OK to disclose your information to this person? \_\_\_\_\_

*Other family and/or friends we may discuss your treatment/health information with:*

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**REFERRAL INFORMATION**

Who referred you or how did you hear about us? \_\_\_\_\_

Referring Physician \_\_\_\_\_

Family Physician \_\_\_\_\_

**PATIENT HEALTH INFORMATION**

Are you currently under the care of a physician? Y N If yes, please explain: \_\_\_\_\_

Have you had any previous fractures or sprains? Y N If yes, please list. \_\_\_\_\_

Have you had any surgeries? Y N If yes, please list: \_\_\_\_\_

**LIFESTYLE/SOCIAL HISTORY**

Please describe your physical activity (list all sports, hobbies, etc): \_\_\_\_\_

Tobacco/Smoke: \_\_\_\_ Current \_\_\_\_ Former \_\_\_\_ Never \_\_\_\_ # Years \_\_\_\_ Packs/Cans per week \_\_\_\_ Year Quit

Do you drink? \_\_\_\_\_ Frequency \_\_\_\_\_ Amount \_\_\_\_\_

Have you ever had a substance abuse problem? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

**ALLERGIES** \*\*\*please fill out completely

**No known drug allergies**

Medication/Food	Severity	Reaction	Onset	Comments

**CURRENT MEDICATIONS** \*\*\*please fill out completely

**No current medications**

Medication	Start Date	Strength	Dosage	Diagnosis

**Have you experienced or do you currently have any of the following?**

**GENERAL**

- \_\_\_\_ Latex allergy
- \_\_\_\_ Fever/Chills
- \_\_\_\_ Weight Loss

**EAR/NOSE/THROAT**

- \_\_\_\_ Frequent respiratory infections
- \_\_\_\_ Sinus problems
- \_\_\_\_ Hay Fever

**RESPIRATORY**

- \_\_\_\_ Tuberculosis (TB)
- \_\_\_\_ Difficulty breathing
- \_\_\_\_ Asthma/Emphysema/COPD

**NEUROLOGIC**

- \_\_\_\_ Fainting spells
- \_\_\_\_ Dizziness
- \_\_\_\_ Seizures
- \_\_\_\_ Frequent headaches

**INFECTIOUS**

- \_\_\_\_ Hepatitis
- \_\_\_\_ HIV+/AIDS

**CARDIOVASCULAR**

- \_\_\_\_ High Blood Pressure
- \_\_\_\_ Heart attack
- \_\_\_\_ Heart murmurs
- \_\_\_\_ Heart valve problems
- \_\_\_\_ Low Blood Pressure
- \_\_\_\_ Congenital Heart Disease
- \_\_\_\_ Rheumatic/Scarlet Fever
- \_\_\_\_ Peripheral vascular disease
- \_\_\_\_ Stroke
- \_\_\_\_ Pacemaker

**ENDOCRINE**

- \_\_\_\_ Hypothyroid
- \_\_\_\_ Hyperthyroid
- \_\_\_\_ Diabetes
- \_\_\_\_ Adrenal disease

**GASTROINTESTINAL**

- \_\_\_\_ Colitis
- \_\_\_\_ Liver disease
- \_\_\_\_ Reflux/GERD

**HEMATOLOGY/ONCOLOGY**

- \_\_\_\_ Anemia
- \_\_\_\_ Clotting disorder
- \_\_\_\_ Pulmonary embolism
- \_\_\_\_ Deep vein clots
- \_\_\_\_ Hemophilia or blood disorder
- \_\_\_\_ Cancer/Chemo/Radiation

**MUSCULOSKELETAL**

- \_\_\_\_ Arthritis/Stiff or painful joints
- \_\_\_\_ Broken bones
- \_\_\_\_ Muscle disease

**GENITOURINARY**

- \_\_\_\_ Frequent UTIs
- \_\_\_\_ Kidney disease

**PSYCHIATRIC**

- \_\_\_\_ Substance abuse
- \_\_\_\_ Psychiatric disorders
- \_\_\_\_ Depression
- \_\_\_\_ Anxiety

**Please explain any of the aforementioned conditions:** \_\_\_\_\_

**Has anyone in your family experienced the following?**

\_\_\_\_\_ Arthritis (type: \_\_\_\_\_)                      \_\_\_\_\_ Diabetes (type: \_\_\_\_\_)  
\_\_\_\_\_ Heart Disease (type: \_\_\_\_\_)                      \_\_\_\_\_ Cancer (type: \_\_\_\_\_)  
\_\_\_\_\_ Muscle Disease (type: \_\_\_\_\_)

**\*\* PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE**

I, the undersigned, authorize payment of medical benefits to gO Orthopedics for any services furnished to me by the physician(s). I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluation and administering claims of benefits.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\* INSURANCE INFO** (no need to fill this out if we have a front & back copy of your insurance cards)

Name & Address of Company \_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber \_\_\_\_\_ Subscriber DOB \_\_\_\_\_

Subscriber SS# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Subscriber's Address \_\_\_\_\_ Subscriber's Phone # \_\_\_\_\_

**IF Workman's Comp:** DOI \_\_\_\_\_ Name of Employer \_\_\_\_\_

**\*\* MEDICARE LIFETIME SIGNATURE ON FILE**

I request that payment of authorized Medicare benefits be made either to me or on behalf of Griggs Orthopedics for any services furnished to me by the physicians. I authorize any holder of medical information about me to be released to the healthcare financing administration and its agents any information needed to determine these benefits or benefits payable for related services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\* SIGNATURE**

I understand that the information that I have given today is correct to the best of my knowledge.

I also understand that this information will be held in the strictest of confidence and will only be shared with those authorized by me on page 1 of this document.

I understand it is my responsibility to inform this office of any change in my medical status.

I hereby authorize the Doctor/Physician and/or Assistant/Nurse to provide medically necessary services, including x-rays, fracture treatment, casting, or other procedures deemed to be in the best interest of the patient.

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office. In addition, by signing below, I hereby consent to the use and disclosure of my healthcare information for treatment purposes, payment activities and healthcare operations of the office.

**Signature of Patient or person legally authorized to sign**

**X** \_\_\_\_\_ **Date** \_\_\_\_\_