go orthopedics

Today's Date _____

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

Name _____ Gender _____ Date of Birth _____

SS# _____ Email* _____

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

Home Ph _____ Cell _____ Work _____

Mailing Address _____ City/State/Zip _____

Employer/Occupation _____ Marital Status _____

Race _____ Ethnicity _____ Language _____

EMERGENCY CONTACT / NEXT OF KIN

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 _____

Mother's Maiden Name _____

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

Name _____ DOB _____ Phone # _____

Address _____ SS# _____

REFERRAL INFORMATION

Who referred you or how did you hear about us? _____

Referring Physician _____ Phone/Address _____

Family Physician _____ Phone/Address _____

LIFESTYLE/SOCIAL HISTORY

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

_____

Tobacco/Smoke (pls circle) **Current** **Former** **Never** _____ # Years _____ #Cigs/day _____ Year Quit

Do you drink? _____ Frequency _____ Amount _____

Have you ever had a substance abuse problem? _____If yes, please explain: _____

PATIENT HEALTH INFORMATION

Height _____ Weight _____ Dominant Hand _____ Current Tetanus? _____

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

_____

Previous fractures, sprains, surgeries? **Y N** If yes, please list: _____

_____

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

GENERAL
_____ Latex allergy
_____ Fever/Chills
_____ Weight Loss

MUSCULOSKELETAL
_____ Arthritis/Stiff or painful joints
_____ Broken bones
_____ Muscle disease

EAR/NOSE/THROAT
_____ Frequent respiratory infections
_____ Sinus problems
_____ Hay Fever

RESPIRATORY
_____ Tuberculosis (TB)
_____ Difficulty breathing
_____ Asthma/Emphysema/COPD

INFECTIOUS
_____ Hepatitis, or HIV+/AIDS

NEUROLOGIC
_____ Fainting spells
_____ Dizziness
_____ Seizures
_____ Frequent headaches

CARDIOVASCULAR
_____ High Blood Pressure
_____ Heart attack / 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

GENITOURINARY
_____ Frequent UTIs
_____ Kidney disease

PSYCHIATRIC
_____ Substance abuse
_____ Psychiatric disorders
_____ Depression / Anxiety

Please explain any of above: _____

Has anyone in your family experienced the following?

_____ Arthritis *(type: _____)*
_____ Heart Disease *(type: _____)*
_____ Muscle Disease *(type: _____)*
_____ Diabetes *(type: _____)*
_____ Cancer *(type: _____)*

ALLERGIES ****please fill out completely* ☐ ***No known drug allergies***

Medication/Food/Other	Severity	Reaction	Onset	Comments

CURRENT MEDICATIONS ****please fill out completely* ☐ ***No current medications***

Medication	Start Date	Strength	Dosage	Diagnosis

**** 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**_____

**** MEDICARE LIFETIME SIGNATURE ON FILE**

I request that payment of authorized Medicare benefits be made either to me or on behalf of gO 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** _____

*** PRESCRIPTION REFILL POLICY ***

For our NON-SURGICAL patients: If warranted and prescribed, we will provide ONE Rx for seven (7) days with ***NO ADDITIONAL REFILLS***. If you require an additional prescription, you must see your primary care physician.

For our SURGICAL patients: As dictated by Senate Bill 18-022 *prescription pain killers shall only be administered for seven (7) days unless otherwise prescribed further by your physician; beyond 14 days you must see your primary care physician.*

I have read and understand the Prescription/Refill Policy as stated above.

X _____ **Date** _____