

Orthopedic Specialists

Dr. _____ Acct# _____ Date _____ Receptionist _____

Patient's Last Name		First		MI	
Date of Birth	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Race	SS#	Marital Status
Home Phone ()	Work Phone ()	Cell Phone ()	Pager ()		
Home Address	Street	Apt. #	City, State, Zip		
Employer's Name		Occupation			
Employer's Address	Street	Ste. #	City, State, Zip		
Primary Care Physician	Address	Street	City, State, Zip	Phone #	
Referred to this Office by <input type="checkbox"/> Patient (name) <input type="checkbox"/> Doctor (name) <input type="checkbox"/> Other					
Allergies to Medications					
IN CASE OF EMERGENCY, PLEASE CONTACT THE FOLLOWING PERSON (NOT LIVING AT PRESENT ADDRESS)					
Name		Relationship to Patient			
Address	Street	Apt.#	City, State, Zip	Phone # ()	
HEALTH INSURANCE INFORMATION					
Primary Insurance			Secondary Insurance		
Name of Insurance Plan			Name of Insurance Plan		
Name of Person Who Carries Insurance			Name of Person Who Carries Insurance		
Relationship to Patient			Relationship to Patient		
Group #			Group #		
ID #			ID #		
Date of Birth of Person Who Carries Insurance			Date of Birth of Person Who Carries Insurance		
Date of Injury	Description of Accident	Is there a personal injury lawsuit pending		<input type="checkbox"/> Y <input type="checkbox"/> N	
PARTY RESPONSIBLE FOR THE BILL IF OTHER THAN PATIENT (IF WORK RELATED, SKIP TO BOTTOM OF FORM)					
Name		Relationship to Patient			
Address	Street	Apt.#	City, State, Zip	Phone # ()	
IF WORK RELATED ACCIDENT FILL OUT BELOW					
Were You Injured on the Job? Please Initial ____ Yes ____ No		Did You Notify Your Employer? <input type="checkbox"/> Y <input type="checkbox"/> N		Date of Accident	
Description of Accident					
Employer's Name					
Worker's Comp Carrier			Claim #		
Address	Street	Apt.#	City, State, Zip	Phone # ()	
Case Manager			Phone # ()		



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Patient Name: _____
(please print)

I understand that my insurance is not a guarantee of payment and that I am financially responsible for all co-pays, deductibles, fees for missed appointments not rescheduled within 24 hours, and non-covered services, as well as obtaining necessary referrals required for payment to be made.

(Signature of patient, parent, or legal guardian)

Date

I authorize release of information to medical suppliers, insurance company(ies), including Medicare, and the use of this form for all insurance submissions and that medical and/or surgical benefit payments can be made directly to my physician or suppliers for services provided.

(Signature of patient, parent, or legal guardian)

Date

I hereby authorize my insurance benefits to be paid directly to Orthopedic Specialists, P.C.

(Signature of patient, parent, or legal guardian)

Date

I understand that I may be referred to a facility in the course of my treatment that my physician or another physician in this group may own or have a financial interest in. Some of those facilities include Timberlake Ambulatory Surgery Center, Imaging Partners of Missouri, St. Louis Spine and Orthopedic Center, MRI Partners of Chesterfield, and Advanced Ambulatory Surgery Center.

(Signature of patient, parent, or legal guardian)

Date

PATIENT HISTORY
FOR MATTHEW D. COLLARD, D.O.

(TO BE UPDATED ANNUALLY)

(PLEASE PRINT)

Name _____ Date of Birth ____/____/____ Age _____ Date _____

- 1) Who referred you to this office? _____
- 2) Who is your current primary care physician? _____
- 3) Who is your cardiologist? _____

- 4) What is your chief problem area at this time? Right/Left _____
- 5) When does the problem occur? (Night, day, what activity or at rest) _____
- 6) How long has the problem been present? _____
- 7) What are your current symptoms? _____
- 8) What is your pain level on a scale from 0 to 10? 0 is no pain and 10 is the most severe pain
Current pain level _____ Pain level at the time of injury _____
Your pain level at its worst _____ Your pain at its best _____ please use the scale for each
- 9) Did you have an injury? Yes or No please circle one (if no, please go to question 10)
Date of injury: ____/____/____ Where did the injury occur? _____
How did the injury occur? _____

How was the injury treated? _____
Results of treatment: _____
- 10) Have you had a previous injury or work related injury to this same area? Yes or No
-Have you had previous surgery on the same area? Yes or No _____
-Date of previous injury: ____/____/____ -How did it occur? _____
- 11) Occupation: _____
Employer: _____ How long have you been at this job? _____
- 12) Have you missed from work? _____ How much? _____ Are you on light duty? Yes or No
- 13) Is this a work-related injury? Yes or No Is an Attorney working on your problem? Yes or No
- 14) For this problem have you had any of the following tests?
 X-rays MRI Nerve Studies CT Scan Bone Scan (check all that apply)
When? _____ Facility Name & Location? _____
- 15) Height _____ Weight _____ Right or Left handed (circle one)
- 16) Have you ever had MRSA (methicillin-resistant staphylococcus aureus) Yes or No
- 17) Do you have any allergies to metals or jewelry? Yes or No
- 18) Do you have any allergies to latex? Yes or No
- 19) Do you take blood thinners of any kind? Yes or No please list _____
- 20) Have you ever had a blood clot, deep vein thrombosis (DVT), or pulmonary embolism (PE)?
Yes or No if yes which? _____
- 21) Are you currently pregnant? Yes or No for x-ray and medication purposes

ALLERGIES (List all medication allergies)

Medications (List all)	

HOSPITALIZATIONS and SURGERIES	List all surgeries
Surgery	Date

Any Problems with Anesthesia? Yes or No

Social History:

Are you married Yes / No Years _____

Do you have children Yes / No Number ____

Do you use a walker or cane?

Do you smoke? Yes/No Packs per day? ____

Do you drink alcohol? Yes / No
Drinks per week? _____

Any history of drug or alcohol abuse? Yes/No

Family History (Check those that apply)

	Self	Mom	Dad	Sibling
Heart Disease/ MI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer type _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acid Reflux/Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your Health History

(PLEASE CIRCLE all that apply)

CONSTITUTIONAL -	NONE	
Fever	Chills	Weight Loss
EAR, NOSE, THROAT -	NONE	
Dizziness	Ear Problems	Sinus Problems
Cold Sore	Deafness	Motion Sickness
CARDIOVASCULAR -	NONE	
Palpitations	Heart Murmur	Chest Pains
High Blood Pressure	High Cholesterol	MI
Vascular Disease	Pacemaker	
RESPIRATORY -	NONE	
Asthma	Bronchitis	Emphysema
Pneumonia	Shortness of Breath	Tuberculosis
GASTROINTESTINAL -	NONE	
Ulcer	Gall Bladder Problems	
Diarrhea Black Stool	Blood in Stool	
GENITOURINARY -	NONE	
Prostate Disease	Frequent Urination	
Pain Urination	Blood in Urine	
MUSCULOSKELETAL -	NONE	
Arthritis	Joint Pains	
Rheumatoid Arthritis	Gout	
ENDOCRINE -	NONE	
Diabetes	Thyroid Disease	
NEUROLOGIC -	NONE	
Headaches	Migraines	
Strokes	Seizures	
PSYCHIATRIC -	NONE	
Depression	Nervousness	Anxiety
HEMATOLOGIC/LYMPHATIC -	NONE	
Bleeding Problems	Anemia	Easy bruising
DVT	PE	Blood Clot
SKIN -	NONE	
Rashes	Itching	
INFECTIOUS DISEASE	Hepatitis	HIV

Pain Level Today

* Circle the number on the line below that represents your pain at its least.

* Circle the number on the line below that represents your pain at its worst.

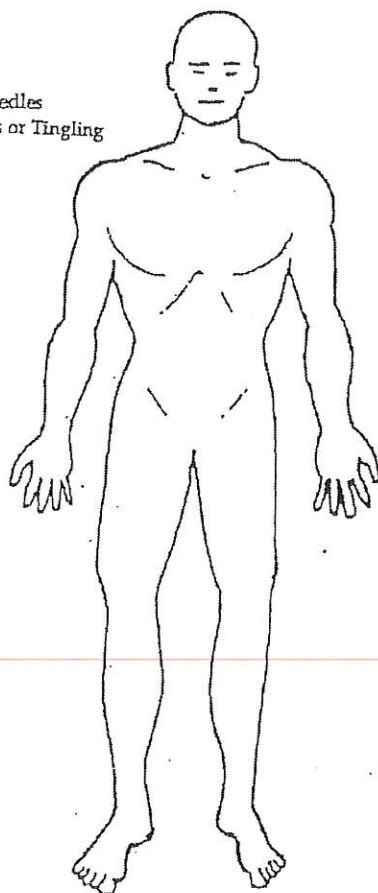
* Place an "X" on the line below that represents your pain **right now**.

0 1 2 3 4 5 6 7 8 9 10
 No Pain Moderate Severe Excruciating

Indicate on the diagram below where your pain is located and what type of pain you feel **at the present time**. Use the symbols to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

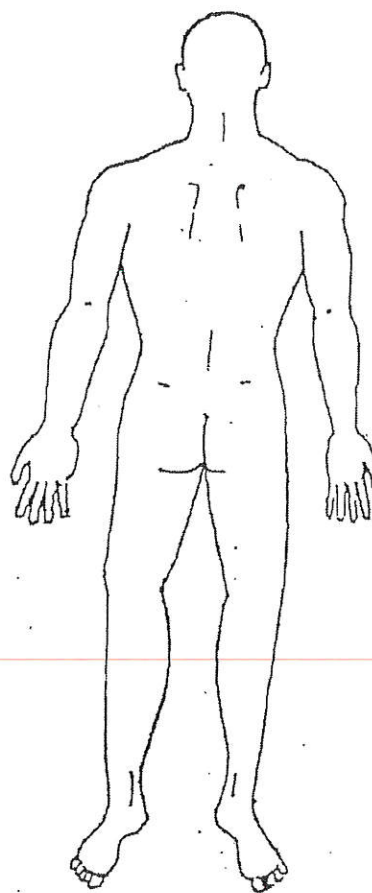
- >>> Sharp
- /// Stabbing
- XXX Burning
- OOO Pins & Needles
- === Numbness or Tingling
- +++ Aching

Right



Front

Left



Right

Back