OrthopedicSpecialists

Dr. ________ Acct# ________ Date ________ Receptionist ________

Patient's Last Name		First		MI
Date of Birth	Age	Sex ☐ M ☐ 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
☐ Patient (name) ☐ Doctor (name) ☐ 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 ☐ Y ☐ 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? ☐ Y ☐ 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 # ( )

OrthopedicSpecialists

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 or 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	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer type ________	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Acid Reflux/Ulcer	☐	☐	☐	☐

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