

PATIENT INFORMATION



Provider you are seeing today? _____ Referred by _____

Private Physician/NP/PA _____

Patient's Name _____ DOB ___/___/___ Age _____ Sex: M F

Height _____ Weight _____ SS# _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email Address _____

Patient's Employer _____ Employer's Address _____

Occupation _____ Phone _____ Length of Employment _____

Spouse/Parent Name _____ DOB ___/___/___ SS# _____ Occupation _____

Spouse/Parent's Employer _____ Phone _____ Length of Employment _____

Emergency Contact _____ Relationship _____ Phone _____

Primary Health Insurance _____ ID# _____ Group# _____

Policyholder's Name _____ DOB ___/___/___ SS# _____

Employer _____

Secondary Health Insurance _____ ID# _____ Group# _____

Policyholder's Name _____ DOB ___/___/___ SS# _____

Employer _____

Is another Insurance Primary to Medicare? _____ If yes what? _____

Is another Insurance Primary to Medicaid? _____ If yes what? _____

Were you injured on the job? _____ Injury date _____ WCB# _____ Carrier Case# _____

Insurance Carrier for Employer _____

Address _____ Work Status _____

Were you injured in an accident? _____ Auto? _____ Liability? _____ Date _____

Claim or Policy # _____ Work Status _____

Name and Address of Insurance Company _____

I hereby give my consent to Buffalo Bone and Joint to use and disclose protected health information about me to carry out treatment, payment, and health care operations, and I authorize payment of medical benefits to the named provider/practice for services rendered. If professional collections are necessary, I understand I will incur additional fees as the patient or guardian.

Signature of Patient or Guardian _____ Date _____

Printed Name of Patient or Guardian _____

MEDICAL HISTORY

Patient's Name _____ Date _____

Reason for Visit _____ Duration _____

If Injury or Accident, give History _____

Allergies: List all allergies to medications or other items, and the nature of the reaction.

ALLERGY	REACTION	ALLERGY	REACTION

Medications: List all medications currently taking

DRUG	STRENGTH	DOSE (How often)

Surgery: List all operations, in-patient or ambulatory.

Any Anesthesia Complications _____

OPERATION	YEAR	OPERATION	YEAR

Using any devices like a cane or walker, etc? _____

Conditions you have or had in the past: (if not listed, please describe _____)

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Prostate problem | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Psychiatric problem | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Goiter | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Vaginal infection |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Migraine headache | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke | |

Symptoms you have or had in the past year: (if not listed, please describe _____)

- | | | | |
|--|---|---|---|
| <p>General</p> <input type="checkbox"/> Chills
<input type="checkbox"/> Depression
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Fainting
<input type="checkbox"/> Fever
<input type="checkbox"/> Forgetfulness
<input type="checkbox"/> Headache
<input type="checkbox"/> Loss of sleep
<input type="checkbox"/> Loss of weight
<input type="checkbox"/> Nervousness
<input type="checkbox"/> Sweats | <p>Muscle/Joint/Bone
 <i>Pain, weakness, numbness in:</i></p> <input type="checkbox"/> Arms
<input type="checkbox"/> Back
<input type="checkbox"/> Feet
<input type="checkbox"/> Hands
<input type="checkbox"/> Hips
<input type="checkbox"/> Legs
<input type="checkbox"/> Neck
<input type="checkbox"/> Shoulders
<p style="text-align: center;">Skin</p> <input type="checkbox"/> Bruise easily
<input type="checkbox"/> Rash
<p style="text-align: center;">Genitourinary</p> <input type="checkbox"/> Blood in urine
<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Lack of control
<input type="checkbox"/> Painful urination | <p>Gastrointestinal</p> <input type="checkbox"/> Poor appetite
<input type="checkbox"/> Bloating
<input type="checkbox"/> Bowel changes
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Excessive hunger
<input type="checkbox"/> Excessive thirst
<input type="checkbox"/> Bleeding gums
<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Loss of hearing
<input type="checkbox"/> Gas
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Indigestion
<input type="checkbox"/> Nausea
<input type="checkbox"/> Rectal bleeding
<input type="checkbox"/> Stomach pain
<input type="checkbox"/> Vomiting
<p style="text-align: center;">Eye, Ear, Nose and Throat</p> <input type="checkbox"/> Vision problems
<input type="checkbox"/> Earache
<input type="checkbox"/> Nosebleeds | <p>Cardiovascular</p> <input type="checkbox"/> Chest pain
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Low blood pressure
<input type="checkbox"/> Irregular heartbeat
<input type="checkbox"/> Poor circulation
<input type="checkbox"/> Varicose veins |
|--|---|---|---|

MEDICAL HISTORY Continued

Family History: List any Medical illnesses in each member.

Father _____

Mother _____

Brother(s) _____

Sister(s) _____

Grandparents _____

Children _____

List any other disease(s) which occur in your family, and the relationship to you _____

Personal Habits

Do you currently use tobacco? _____ In the past? _____ Never _____ Type and amount _____

Do you currently use alcohol? _____ Type _____ Never _____ Weekly amount _____

Do you currently use drugs? _____ In the past? _____ Never _____ Type and amount _____

Diet History: Describe any special diets you follow.

Exercise History: Describe what types of exercise you perform and how often.

Educational History: List highest grade completed and degree received.

Occupational History: Describe the current work you perform or may have performed in the past.

Are you currently working? _____ YES _____ NO _____

Please include any questions or comments not already on this form.

Signature of Patient or Guardian _____ Date _____

Reviewed by Provider _____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____