PATIENT DEMOGRAPHICS

PATIENT ID # _____
(Please Leave Blank)

Please Use BLACK INK

NWIA BONE, JOINT & SPORTS SURGEONS, P.C.

PATIENT'S NAME _____
Last First Middle

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE _____ CELL PHONE _____

SOCIAL SECURITY # _____ SEX _____ BIRTHDATE _____ AGE _____

EMPLOYER _____ ADDRESS _____ EMPLOYER PHONE # _____

RACE ☐ Caucasian ☐ Asian ☐ Hispanic/Latino ☐ African American ☐ American Indian ☐ Native Hawaiian

MARITAL STATUS M___S___W___D___Sep____ E-MAIL ADDRESS: _____

WORK STATUS ☐ Working (☐ Full-Time ☐ Part-Time) ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student

GUARANTOR *(If Patient is a Minor)

Name _____
Birthdate _____
Employer _____
Employer Address _____
Full Time or Part Time Employment _____
Telephone (primary) _____
Telephone (work) _____
Social Security # _____

INSURED SUBSCRIBER INFORMATION *(If not patient)

Name _____
Birthdate _____
Employer _____
Employer Address _____
Full Time or Part Time Employment _____
Telephone (primary) _____
Telephone (work) _____
Social Security # _____

NEAREST FRIEND OR RELATIVE WE MAY CONTACT IN CASE OF EMERGENCY

Name _____ Relationship _____ Phone _____

If you have Health Insurance, please present your card(s) to the front desk, along with your photo ID.

Is this a Worker's Compensation claim? Yes____ No____ Date of Injury _____

Employer _____ Address _____

Accident Related? Yes ☐ No ☐ Auto? Yes ☐ No ☐ Other? Yes ☐ No ☐ Date of Accident _____

Personal Physician _____ Referring Physician _____

I do hereby voluntarily consent to permit any associated physician, therapist or assistant of **NWIA Bone, Joint & Sports Surgeons, PC** to perform diagnostic procedures and such medical treatment or procedures as is necessary or advisable in their judgment for my medical care. I authorize **NWIA Bone, Joint, & Sports Surgeons, PC** to release Medical information per HIPAA regulations about me to myself, my insurance company, workman's compensation or other medical provider for continuity of my care. I authorize direct payment of medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to **NWIA Bone, Joint & Sports Surgeons, PC**. I understand that I am fully responsible and guarantee payment of services rendered by anyone in this office. I also permit a copy of this authorization be used in place of the original. This assignment will remain in effect until revoked by me in writing. Discrimination is against the law, **NWIA Bone, Joint & Sports Surgeons, PC** complies with applicable federal civil rights and does not discriminate on the basis of race, color, national origin, age, disability or sex. My signature below also indicates that I have been given an opportunity to read the Notice of Nondiscrimination and Accessibility Requirements for **NIWA Bone, Joint & Sports Surgeons, PC** and have any questions answered before signing.

Patient / Guardian Signature: _____ **Date:** _____
(Parent signature if patient is under 18)

NWIA BONE JOINT AND SPORTS SURGEONS Patient ID _____

Name: _____ Date of Birth: _____

PRESENT HISTORY:

What is your chief complaint for this visit? _____

Date of Accident or onset of symptoms _____

Describe how your symptoms started (if due to injury, how were you injured?) _____

Have you had any treatment for this condition to date? ☐ Yes ☐ No If yes, Date: _____ Where: _____

Please indicate any treatment that has occurred:

☐ Hospitalization ☐ Surgery ☐ Therapy ☐ Medication ☐ X-rays ☐ Injections

Have you ever had similar symptoms prior to this episode? ☐ Yes ☐ No

If yes, when _____ How was it treated? _____

PLEASE LIST MEDICATION ALLERGIES: _____

Other Allergies: _____ Latex Allergy: ☐ YES ☐ NO

Current Medications: _____

_____

All Other Medical Problems & Previous Surgeries: _____

_____

SOCIAL HISTORY:

Work status: ☐ Working ☐ Unemployed ☐ Disabled ☐ On leave ☐ Retired ☐ Student

Occupation _____ ☐ Full-Time ☐ Part-Time

Do you smoke? ☐ Yes ☐ No If yes, how many packs a day? _____ For how many years? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks at a time? _____

Illegal Drug Use ☐ Never ☐ In the past ☐ Currently Types of Drugs _____

Height _____ Weight _____ Pharmacy _____

FAMILY HISTORY: Check all that apply ☐ None apply

☐ Heart problems	☐ Diabetes	☐ Arthritis	☐ Bleeding problems
☐ Seizure	☐ Cancer	☐ High Blood Pressure	☐ Stroke
☐ Gout	☐ Kidney problems	☐ Lung problems	☐ Mental Illness
☐ Alcoholism	☐ Blood clots (legs or lungs)		

Other: _____

PERSONAL MEDICAL HISTORY: Have you ever had any of the following? (Please check all that apply and describe below)

☐ Breathing Problem	☐ Sleep Apnea	☐ Kidney Problem	☐ Heart Disease	☐ Cancer	☐ Ulcers
☐ Hepatitis	☐ Stroke	☐ AIDS	☐ MRSA	☐ Diabetes	☐ Cardiac Disease
☐ High Blood Pressure	☐ Blood Transfusion	☐ Blood Antibody	☐ Post-Surgical Wound Infection		

REVIEW OF SYSTEMS: (in the past 30 days have you experienced any of the following?)

☐ Fever	☐ Sleep apnea (snoring)	☐ Nausea	☐ Chills	☐ Hoarseness
☐ Vomiting	☐ Weight loss	☐ Cough	☐ Diarrhea	☐ Weight gain
☐ Trouble swallowing	☐ Constipation	☐ Headache	☐ Chest pain	☐ Hemorrhoid
☐ Glasses/Contacts	☐ Palpitations	☐ Stomach pain	☐ Hearing loss	☐ Swollen ankles
☐ Urinary difficulty	☐ Dizziness	☐ Shortness of breath	☐ Anxiety	☐ Ear pain
☐ Seasonal allergies	☐ Hyperactivity	☐ Nosebleeds	☐ Skin rashes	☐ Memory loss
☐ Toothache	☐ Swollen glands	☐ Blackouts	☐ Gum problems	☐ Poor appetite

☐ Other: _____ ☐ ***I have not experienced any of the above symptoms in the last 30 days***

I have read and confirmed the above information with the patient:

NWIABJSS Physician Signature: _____ Date: _____