SOUTHERN ORTHOPEDICS & SPINE: NEW PATIENT INFORMATION

Name: **SS#:** Date of Accident/Injury:

Local Address: City: State: Zip:

Home Phone: Cell Phone:

Age: Date of Birth: / / Marital Status:
MONTH DAY YEAR

If Minor, Responsible Parties:

Address: Phone:

Occupation: Business Phone: ( )

Business Name: Business City/State:

Medical Insurance (if applicable): / /

Auto Insurance (if applicable): / /

Auto Insurance (Claim Numbers): / /
AUTO INSURANCE COMPANY POLICY NUMBER ADJUSTOR NAME
ACCIDENT CLAIM # INJURY CLAIM #

Do you have an attorney: If "YES," Attorney Name:

Attorney Contact (Case Manager, Paralegal, etc.):

Attorney Address or City/State:

Attorney Phone:

Referring Physician: Referring Physician City/State:

Emergency Contact : Emergency Phone:

I acknowledge that the above information is true and accurate to the best of my knowledge. I will notify Southern Orthopedics & Spine if any of the above information changes.

PATIENT'S PRINTED NAME

PATIENT'S SIGNED NAME

FOR OFFICE USE ONLY: Date Received Date Completed Initials

Bradenton Sarasota

Southern Orthopedics & Spine—4016 Sawyer Road—Sarasota, FL 34233 Phone: 941-216-4700—Fax: 941-921-2414

SOUTHERN ORTHOPEDICS & SPINE—NEW PATIENT MEDICAL HISTORY

Today's Date ____/____/____ Patient Name _____

Date of Birth ____/____/____ Referring Physician _____

Reason for Visit? _____

Primary Care Physician: _____ Cardiologist: _____

Were you seen in Emergency Room?
Yes ◯ No ◯

Which Hospital? _____

Is this a Motor Vehicle Accident or Personal Injury Accident?

Yes ☐ No ☐

Do you have a lawyer?

Yes ☐ No ☐

Are you disabled? Yes ☐ No ☐

Any x-rays, MRIs, or CTs related to injury? Yes ☐ No ☐

Performed where? _____

Family History (Parents or Siblings)

Check all that apply

- ☐ AIDS/HIV
- ☐ ALCOHOLISM
- ☐ ARTHRITIS
- ☐ BLEEDING DISORDERS
- ☐ CANCER
- ☐ DIABETES
- ☐ GOUT
- ☐ HEART DISEASE
- ☐ KIDNEY DISEASE
- ☐ STROKE
- ☐ TB
- ☐ OTHER_____

Medical History (Personal)

Check all that apply

- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ASTHMA/COPD
- ☐ BACK DISORDERS
- ☐ BLEEDING DISEASE
- ☐ BLOOD CLOTS
- ☐ CANCER/WHERE?_____
- ☐ COLITIS/DIVERTICULITIS
- ☐ DIABETES

CIRCLE ALL THAT APPLY

- ☐ EMPHYSEMA
- ☐ INFECTION
- ☐ NEUROLOGICAL PROBLEMS
- ☐ SEIZURES
- ☐ REFLUX
- ☐ TB
- ☐ STOKE / TIA
- ☐ BROKEN BONE/WHAT?
- ☐ _____
- ☐ GALLBLADDER DISEASE
- ☐ GOUT
- ☐ HEART DISEASE
- ☐ HEART ATTACK/WHEN?__
- ☐ _____
- ☐ HEPATITIS
- ☐ HIATAL HERNIA
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV
- ☐ KIDNEY DISEASE/STONES
- ☐ STROKE
- ☐ THYROID DISEASE

Other Problems

Check all that apply

- ☐ Abnormal Heartbeat
- ☐ Anesthesia Difficulties
- ☐ Calf Cramps
- ☐ Chills/Fever
- ☐ Diarrhea
- ☐ Ear/Nose/Throat
- ☐ Hearing Loss
- ☐ Heart/Chest Pain/Angina
- ☐ Indigestion/Heartburn
- ☐ Intestinal Bleeding
- ☐ Joint Pain/Stiffness
- ☐ Leg/Skin Ulcers
- ☐ Muscle Weakness
- ☐ Recent Weight Loss
- ☐ Shortness of Breath

Previous Surgeries

Check all that apply

- ☐ APPENDIX
- ☐ BACK
- ☐ BONE/JOINT/WHERE?
- ☐ _____
- ☐ CANCER/WHERE?
- ☐ _____
- ☐ GALLBLADDER
- ☐ HEART BYPASS/STENT
- ☐ HYSTERECTOMY
- ☐ PROSTATE
- ☐ TONSILS
- ☐ OTHERS/LIST_____
- _____

Social History

Married ☐ Single ☐ Divorced ☐

Do you live alone? Yes ☐ No ☐

Do you SMOKE? Yes ☐ Packs a day ____
No ☐ When did you quit?
_____

ALCOHOL? Social ☐ Heavy ☐ ever ☐

AGE _____ **MALE** ☐ **FEMALE** ☐

HEIGHT_____ **WEIGHT** _____

PHARMACY NAME

_____

PHARMACY PHONE

_____

CURRENT MEDICATIONS (STRENGTH & DOSAGE)_____

_____

_____

_____

ARE YOU ON BLOOD THINNERS?

YES ☐ **NO** ☐ **WHAT?**_____

ALLERGIES—LIST ALL _____

_____

_____

_____

Patient's/Guardian's Signature:

_____

OFFICE USE ONLY DATE

MD SIGNATURE _____

_____ _____

_____ _____

_____

SOUTHERN ORTHOPEDICS & SPINE INJURY QUESTIONNAIRE

Patient Name:_____ **Date of Birth:**_____

Date of Injury: _____

What state did the injury occur in? _____

What complaints are due to this injury?

_____

_____

How did the injury occur? _____

Is this a work related injury? ☐ Yes ☐ No If yes was it reported to workers comp? ☐ Yes ☐ No

Have you ever had these complaints before? ☐ Yes ☐ No

Were you having any of these problems 6 months prior to the injury? ☐ Yes ☐ No

Did you hit your head? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No

Did you immediately go to the hospital? ☐ Yes ☐ No

If not, when? _____ Name & Location? _____

What Doctors have you seen due to this injury? _____

_____

Did you have any imaging studies after the injury? ☐ Yes ☐ No

If so, what type of studies (CT, MRI, X-rays, etc)? _____

_____

Have you had a prior motor vehicle accident? ☐No ☐Yes

If Yes, when did the accident(s) occur and what were your complaints after the accident(s)?

_____

Patient Signature:_____ **Date:** _____