SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

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PATIENT INFORMATION (ESTABLISHED NEW PROBLEM)

PATIENT'S NAME_____**DATE** _____

HAVE YOU EVER BEEN TREATED BY THESE DOCTORS? ☐ **Yes** ☐**No** **If so, what doctor?** _____

CELL PHONE _____**HOME PHONE** _____

ADDRESS_____

CITY_____**STATE**_____**ZIP**_____

MARITAL STATUS: ☐**Married** ☐ **Single** ☐ **Divorced** ☐ **Widow** **AGE**_____

PRIMARY DOCTOR: Dr._____ **Address**_____

PHARMACY NAME_____ **LOCATION**_____ **PHONE**_____

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NOTATE ANY CHANGES TO EMPLOYMENT AND/OR HEALTH INSURANCE SINCE YOUR LAST VISIT:

EMPLOYER'S NAME & ADDRESS _____

EMPLOYER'S PHONE #_____**OCCUPATION**_____

NAME OF SPOUSE/ PARENT_____

SPOUSE/PARENT ADDRESS_____

SPOUSE/PARENT SOCIAL SECURITY #/ _____

SPOUSE/PARENT EMPLOYER'S NAME _____

SPOUSE/PARENT EMPLOYER'S PHONE _____

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT _____

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PRIMARY INSURANCE COMPANY NAME _____

PRIMARY INSURANCE COMPANY ADDRESS _____

GROUP # _____**POLICY #**_____**SUBSCRIBER NAME** _____

SUBSCRIBER DATE OF BIRTH _____**SUBSCRIBER SOCIAL SECURITY #**_____

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SECONDARY INSURANCE COMPANY NAME _____

SECONDARY INSURANCE COMPANY ADDRESS _____

GROUP # _____**POLICY #**_____**SUBSCRIBER NAME** _____

SUBSCRIBER DATE OF BIRTH_____**SUBSCRIBER SOCIAL SECURITY #**_____

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MEDICAL HISTORY & INTAKE FORM (ESTABLISHED NEW PROBLEM)

Patient's Name:_____ **Date**: _____

PATIENT HISTORY:

Reason for visit:_____**Patient Age:**_____

For how long has this been bothering you? _____

If Upper Extremity Involved, What is Your Dominant Hand **Right**☐ **Lef**☐

Pain at Rest or Pain That Awakens From Sleep? _____

Severity (Mild/Moderate/Severe)_____

What Makes Symptoms Better? _____

What Makes Symptoms Worse? _____

Describe Any Prior Treatment (Surgery/Therapy/Injections/Medications)

_____

_____

_____

_____

ANY NEW MEDICAL PROBLEMS OR SURGERIES SINCE YOUR LAST VISIT:

_____

_____

_____

SOCIAL HISTORY - ANY CHANGES IN THE FOLLOWING SINCE YOUR LAST VISIT:

Employment_____

Living Situation_____Alcohol Use (amount & type)_____

Drug Use (amount & type)_____Tobacco Use (# of packs/cigarettes daily)_____

ANY NEW ALLERGIES:

_____

_____

ANY NEW MEDICATIONS SINCE YOUR LAST VISIT (INCLUDING VITAMINS AND SUPPLEMENTS):

_____

_____