Patient Accident Questionnaire

Patient Name: _____ **Account Number**: _____

Was this accident work related? ***YES_____NO___

Was this accident a personal injury? ***YES_____NO_____

Was this accident a motor vehicle injury? YES____NO_____

      If yes, is the claim outstanding? ***YES_____NO_____

      If not, when was it closed? _____

 Is there a third party responsible? ***YES____NO____

      If yes, is the claim outstanding? ***YES____NO___

      If not, when was it closed? _____

Were you previously treated for this condition? YES____NO____

      If yes, please provide the following information:

      Date and time of accident: _____

      Location of accident: _____

Explanation on how accident happened, and injuries sustained:

_____

_____

_____

_____

***This office does not accept third party insurance. Please indicate the name(s) of your insurance company that will be responsible for this incident. **You will be responsible for all balance(s) due after your insurance paid and/or if your claim is denied.**

1) _____

2) _____

Patient Signature: _____**Date**: _____

Employee initials: _____

IF THIS CONDITION IS A RESULT OF A <u>WORK INJURY</u>, PLEASE DO **NOT** COMPLETE THIS FORM. PLEASE NOTIFY OUR FRONT OFFICE ASSISTANT

PATIENT'S PERSONAL INFORMATION

(CIRCLE ONE) Birth Sex: MALE   FEMALE

Legal Name: _____ _____ _____
LAST NAME   FIRST NAME   MI

Street Address:_____ City:_____ State:_____ ZIP:_____

Date of Birth:_____ Age:_____ Marital Status: (CIRCLE ONE) Single • Married • Divorced • Widowed

Home Phone: (   )_____ Cell Phone: (   )_____ Driver's License #:_____

E-mail:_____ Social Security #:_____

Reason for today's visit: _____

Is this visit the result of an accident/injury? ____Yes ___No If yes, please give us the approximate date:_____

PATIENT/RESPONSIBLE PARTY INFORMATION

☐**Check here if you are the patient & responsible party**

Responsible party:_____ Relationship to Patient_____ Social Security # _____ DOB:_____

Responsible party's home/cell phone: (   )_____ Work phone: (   )_____

Street Address:_____ City:_____ State:_____ ZIP:_____

☐**Address same as above**

INSurance INFORMATION

PRIMARY Insurance:_____

Name of Insured:_____ DOB:_____ Relation to Patient:_____

Primary Insurance ID number:_____ Primary Insurance Group Number: _____

Employer's Name:_____ Phone Number: (   )_____

SECONDARY Insurance:_____

Name of Insured:_____ DOB:_____ Relation to Patient:_____

Secondary Insurance ID number:_____ Secondary Insurance Group Number: _____

Employer's Name:_____ Phone Number: (   )_____

PATIENT'S REFERRAL INFORMATION

Who may we thank for referring you? _____

Name of your family physician:_____ Family Physician's Phone Number: ( )_____

Is there a third party responsible? __Yes ___No If yes, is the claim outstanding? __Yes ___No   If yes, please notify staff

Have you been seen by one of our physicians before? _Yes___ No If yes, please give us the approximate date: _____

Have you been seen at any OrthoWest location? ☐ Platinum Orthopaedics ☐ South County Orthopaedics ☐ Los Alamitos Orthopaedic

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship:_____

Street Address:_____ City:_____ State:_____ ZIP:_____

Phone Number (Home/Cell): (   )_____ Phone Number (Work): (   )_____

Consent to Examination • Authorization to Release Information • Assignment of Benefits • Financial Agreement

I hereby authorize the above physician to perform an orthopedic consultation and examination, and to initiate diagnostic and therapeutic treatments that may be considered advisable or necessary. I hereby authorize the above physician to release to the insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby give lifetime authorization for payment of insurance benefits to be made directly to the physician rendering service. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize these physicians to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature:_____ Date:_____ *Employee Initials:*_____

Medical History Information

Please fill out every section. If none apply, please check **NONE**. Thank You.

Patient Name: _____ Date of Birth: _____

Patient Height: _____ Patient Weight: _____

Birth Gender: ☐ MALE ☐ FEMALE   Current Gender Identity: ☐_____
    (Check One)   *(optional)*

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Pharmacy Information

Preferred Pharmacy: _____

Pharmacy Address or Cross Streets and City: _____

Pharmacy Phone Number: _____

Past Medical History

☐	Anxiety	☐	HIV/AIDS
☐	Depression	☐	High Cholesterol
☐	Asthma	☐	Thyroid Problems
☐	Arrhythmia	☐	Neuropathy
☐	Coronary Artery Disease	☐	Seizures
☐	Pacemaker	☐	Stroke
☐	Cancer Type: _____	☐	COPD
☐	Diabetes Type: _____	☐	DVT (Deep Vein Thrombosis)
☐	Hepatitis Type: _____	☐	Other: _____
☐	High Blood Pressure	☐	**NONE**
☐	Heart Disease		

Past Surgical History

☐	Appendix Removed	☐	Kidney Removed
☐	Bladder Removed	☐	Mastectomy ( )Left ( )Right
☐	Breast Augmentation	☐	Prostate Biopsy
☐	Breast Biopsy	☐	Other: _____
☐	Gallbladder Removed	☐	**NONE**
☐	Hysterectomy		
☐	Ovaries Removed		

Orthopaedic History

☐	Bursitis	☐	Sciatica
☐	Epidural Injections (Spine)	☐	Cervical Spinal Stenosis
☐	Fracture Type: _____	☐	Lumbar Spinal Stenosis
☐	Carpal Tunnel Syndrome	☐	Vertebral Compression Fracture
☐	GOUT	☐	Vitamin D Deficiency
☐	Osteoarthritis	☐	Other: _____
☐	Osteopenia	☐	**NONE**
☐	RSD (Reflex Sympathetic Dystrophy		
☐	Rheumatoid Arthritis		

Medical History Information
Please fill out every section. If none apply, please check **NONE**. Thank You.

Orthopaedic Surgical History

☐   Ankle Surgery ( )Left ( )Right   ☐   Hip Replacement ( )Left ( )Right
☐   Knee Arthroscopy ( )Left ( )Right   ☐   Knee Replacement ( )Left ( )Right
☐   ACL Reconstruction   ☐   Shoulder Replacement ( )Left ( )Right
☐   Shoulder Arthroscopy   ☐   Trigger Finger Release ( )Left ( )Right
☐   Carpal Tunnel Decompression   ☐   Other: _____
☐   Cervical Spine ( )Fusion ( )Decomp   ☐   **NONE**
☐   Lumbar Spine ( )Fusion ( )Decomp
☐   Intramedullary Nailing Femur/ Tib/Fib

Current Physicians

☐   Primary Care Physician   **Name/Phone**_____
☐   Pediatric   **Name/Phone**_____
☐   Cardiologist   **Name/Phone**_____
☐   Pain Management   **Name/Phone**_____
☐   Physical Therapy   **Name/Phone**_____

Medications   Allergies to Medications

*MUST PROVIDE **ALL** MEDICATION CURRENTLY TAKING*

_____   _____

_____   _____

_____   _____

_____   _____

_____   _____

_____

☐   **Separate list provided**   ☐   **Separate list provided**
☐   **NONE**   ☐   **NONE**

*If you have a medication list, please hand it to the Receptionist or Medical Assistant so it can be scanned into your chart.