Hillsboro Orthopedic Group, Inc. – Bart Rask, MD

PATIENT INFORMATION FORM

Date: _____

Patient's name (last, first, mi): _____

What name does the patient prefer to be addressed as: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell phone: _____

EMAIL address: _____

☐ Male ☐ Female Date of Birth: _____ Age: _____

Drivers License No: _____ Social Security: _____

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

Spouse's name: _____ Daytime phone: _____

_____

If a student, patient's school: _____

Patient's employer: _____

Occupation: _____ Work phone: _____

Current work status: ☐ Working normal job at normal hours ☐ Not employed or retired

☐ Working light or limited duty ☐ Disabled ☐ School ☐ Other: _____

_____

If patient is under 18 - Parent's names and daytime phone numbers:

Father: _____ Phone: _____

Mother: _____ Phone: _____

Name of contact/emergency person not living with patient: _____

Relationship to patient: _____ Phone: _____

GENERAL INFORMATION

Body part affected: _____ ☐ Left ☐ Right ☐ Both

Are you: ☐ Left handed ☐ Right handed ☐ Ambidextrous

Were you injured?: ☐ Yes ☐ No Date of injury: _____

How long have you had symptoms?: _____

Where did the accident happen?: ☐ Home ☐ Work ☐ Auto ☐ Sports ☐ Other

Describe how you were injured: _____

Primary Care Physician (PCP): _____Phone: _____

Were you referred to this office by the patient's PCP?: ☐ Yes ☐ No

If not, how were you referred to our office? _____

- ◆ **Note: If patient's insurance requires a prior authorization/referral from PCP, please make sure all arrangements to do so have been made**. ◆

BILLING INFORMATION

Primary Insurance: _____ Phone: _____

Subscriber name: _____Subscriber DOB: _____

ID Number: _____ Group number: _____

Secondary Insurance: _____ Phone: _____

Subscriber name: _____Subscriber DOB: _____

ID Number: _____ Group number: _____

I hereby authorize the Hillsboro Orthopedic Group, Inc. to release to the insurance companies named on this form and to my primary care physician any information obtained in the course of my examination and/or treatment. If my insurance company requires that a referral from my primary care physician be on file before service in our office can be preformed, I agree to full responsibility for all expenses incurred and hereby assign Hillsboro Orthopedic Group any and all insurance benefits due to me to the full extent of my financial obligation to the Hillsboro Orthopedic Group.

X _____ Date: _____

(Patient's signature ⋯ must be signed by parent-guardian if patient is under the age of 15)

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PATIENT HEALTH INFORMATION

Patient name: _____ Date: _____

Medical Problems: Have you had problems in any of these areas? **Circle all that apply.**

Cancer · Type: _____

Heart attack, heart valve, stents

High blood pressure, High Cholesterol

Lung: Emphysema, TB, asthma, COPD

Gastrointestinal, bowel

Autoimmune disease

Diabetes: Last A1C:_____ Date:_____

Thyroid

Arthritis

Eyes, ears, nose, throat

Kidney disease

Hepatitis, Liver disease

Seizures, stroke, fainting

Other_____

If you have had any of the above, please explain: _____

_____

Do you have an advanced directive/living will?: ☐ Yes ☐ No

If yes, where is it on file?: _____

List routine medications/dosages:

_____ _____

_____ _____

_____ _____

Do you use aspirin, ibuprofen or blood thinners on a regular basis?: ☐ Yes ☐ No

How much?: _____

Medication Allergies: _____

Surgeries: Have you ever had major surgery?: ☐ Yes ☐ No

Date:	**Type:**	**Date:**	**Type:**
_____	Appendectomy	_____	Heart Surgery
_____	Hysterectomy	_____	Lung Surgery
_____	Pacemaker	_____	Gallbladder Surgery
_____	Prosthetic Joint	_____	Bowel Surgery
_____	_____	_____	_____
_____	_____	_____	_____

Do you smoke?: ☐ Yes ☐ No If yes, how much?: _____

Do you consume alcohol?: □ Yes □ No If yes, how much?: _____