



# Patient Information Form

Chart# \_\_\_\_\_

Patient Name \_\_\_\_\_  
LAST FIRST MIDDLE

Address \_\_\_\_\_  
STREET, P.O. BOX AND OR SUITE #

\_\_\_\_\_ CITY STATE ZIP

Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

DOB \_\_\_\_\_ SSN # \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Employer \_\_\_\_\_ Primary Ins. Carrier \_\_\_\_\_

Patient ID # \_\_\_\_\_ Policy # \_\_\_\_\_

Secondary Ins. Carrier \_\_\_\_\_

Patient ID # \_\_\_\_\_ Policy # \_\_\_\_\_

**Please fill out the name of the primary cardholder of your insurance if it is different from the patient above.**

Name \_\_\_\_\_  
LAST FIRST MIDDLE

DOB \_\_\_\_\_ SSN # \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Employer \_\_\_\_\_ Work # \_\_\_\_\_

## PERMISSION TO GIVE MEDICAL INFORMATION

I, \_\_\_\_\_ hereby authorize the physician and staff of Powell Orthopedics, P.A. to contact in case of emergency, or to discuss any information about health, well being, or appointments concerning the patient, with myself or spouse or with the following person or people.

1. Name \_\_\_\_\_ Phone # \_\_\_\_\_

2. Name \_\_\_\_\_ Phone # \_\_\_\_\_

This is also an agreement to obtain medical services, assignment of benefits and authorization to release medical information. I authorize any holder of medical information about me to release it to Powell Orthopedics P.A. and or staff, any information needed. I also agree to an automated telephone system to call and remind me of a scheduled appointment and I acknowledge receiving a copy of the HIPAA notice of privacy practice today. Powell Orthopedics P.A. is also authorized to furnish to any insurance company, 3rd party payer, hospital or physician any and all information it may have concerning the patient, including, but not limited to, medical history, reports, consultations, prescriptions, treatment, x-rays, and all other requested information or documentation pertaining shall be considered as a valid and effective as the original.

\_\_\_\_\_  
SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN Date \_\_\_\_\_



# New Patient Information

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
DOB \_\_\_\_\_ Age \_\_\_\_\_  
Referring Physician \_\_\_\_\_ M \_\_\_ F \_\_\_ Dominant Hand: R L Both

## PLEASE TELL US ABOUT YOUR ORTHOPEDIC PROBLEM:

When did it begin? \_\_\_\_\_ What caused it? \_\_\_\_\_  
Previous Treatment? Yes No By whom? \_\_\_\_\_ When? \_\_\_\_\_

### PAST SURGICAL HISTORY (please list)

1. \_\_\_\_\_ Dr. \_\_\_\_\_ Date \_\_\_\_\_
2. \_\_\_\_\_ Dr. \_\_\_\_\_ Date \_\_\_\_\_
3. \_\_\_\_\_ Dr. \_\_\_\_\_ Date \_\_\_\_\_
4. \_\_\_\_\_ Dr. \_\_\_\_\_ Date \_\_\_\_\_
5. \_\_\_\_\_ Dr. \_\_\_\_\_ Date \_\_\_\_\_
6. \_\_\_\_\_ Dr. \_\_\_\_\_ Date \_\_\_\_\_

### PAST MEDICAL HISTORY: (circle all that apply)

- |                |                          |                   |                  |
|----------------|--------------------------|-------------------|------------------|
| Heart Disease  | High Blood Pressure      | Heart Attack      |                  |
| Stroke         | Congestive Heart Failure | Bleeding Disorder |                  |
| Blood Clots    | Pulmonary Embolis        | Lung Disease      |                  |
| Emphysema      | Asthma                   | COPD              | Cancer           |
| Kidney Disease | Liver Disease            | Diabetes          | Seizure Disorder |
- Other Health Problems: \_\_\_\_\_

### MEDICINES (prescription and non-)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

### Hospitalizations (for what and when?):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### ALLERGIES (medicine or other)

\_\_\_\_\_  
\_\_\_\_\_

### LEGAL

Problem due to an accident? Yes No Is litigation planned? Yes No  
Auto accident? Yes No Attorney's name: \_\_\_\_\_  
Do you have an attorney? Yes No Address/Phone: \_\_\_\_\_

### PERSONAL AND FAMILY

Do you use tobacco? Yes No Amt. per day? \_\_\_\_\_ Since? \_\_\_\_\_  
Do you use alcohol? Yes No Amt. per day? \_\_\_\_\_ Since? \_\_\_\_\_  
Most physically demanding regular activity? \_\_\_\_\_ How often? \_\_\_\_\_

Occupation \_\_\_\_\_ Time at present employer? \_\_\_\_\_ Previous? \_\_\_\_\_

Marital Status: (circle) Single Married Divorced Widowed Living Status: (circle) Alone Spouse Children Parents Friend(s)

Family Health: (List health problems. If deceased, please note age of death.)

Father \_\_\_\_\_ Mother \_\_\_\_\_  
Siblings \_\_\_\_\_ Children \_\_\_\_\_

