

# WELCOME

A Southeastern Orthopaedic Care Center

Date \_\_\_\_\_

Acct.# \_\_\_\_\_

Doctor \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone #: ( ) \_\_\_\_\_

## 1 ABOUT YOU

Patient's Full Name

\_\_\_\_\_

First MI Last

Street Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

City State Zip Code

Home Phone #: ( ) \_\_\_\_\_

Male  Female  Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

SS# \_\_\_\_\_

Circle: Single Married Divorced Widowed

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Work Phone #: ( ) \_\_\_\_\_ Ext. \_\_\_\_\_

If Student, School? \_\_\_\_\_

What BODY PART are we seeing you for today? \_\_\_\_\_

Is your complaint due to injury or illness? (circle one)

Is your injury or illness on: (circle one) Right Side or Left Side

Due to: (circle one) Work Auto Accident Other

If accident, where did it occur? \_\_\_\_\_

What date did your illness or injury start? \_\_\_\_\_

Is legal action pending? \_\_\_\_\_

If so, attorney's name? \_\_\_\_\_

If accident, state occurred in \_\_\_\_\_

Full Name of Referring Doctor: \_\_\_\_\_

Full Name of Primary Care Doctor \_\_\_\_\_

## 2 Spouse (or Parent if minor) Information

Spouse or Parent Name \_\_\_\_\_

Spouse or Parent SS# \_\_\_\_\_ Phone # \_\_\_\_\_

Spouse or Parent Address \_\_\_\_\_

Spouse or Parent Employer \_\_\_\_\_ Phone # \_\_\_\_\_

## 3 INSURANCE

### PRIMARY INSURANCE

Insurance Co. Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthday: \_\_\_\_\_ SS# \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

### SECONDARY INSURANCE

Insurance Co. Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthday: \_\_\_\_\_ SS# \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

I authorize consent for treatment, the release of any medical information necessary to process this claim, and authorize payment of medical benefits to the Southeastern Orthopaedics, for services provided as described on their standard claim form. I understand that I am financially responsible for the charges covered by this authorization. You, the patient, may be referred to a facility in which Southeastern Orthopaedics/Maryville Orthopaedic Clinic has a financial interest such as SEO Imaging. Maryville Orthopaedic Clinic physicians have ownership interest in Maryville Surgical Center. You may be referred to this facility for necessary medical services. You, as the patient, are free to choose to use these facilities or seek these medical services elsewhere. If you object to using these associated resources, please advise your physician and you will be referred to another comparable facility.

I will be paying today by: CASH  CHECK  CREDIT CARD

SIGNATURE: \_\_\_\_\_  
(IF UNDER 18, PARENT OR GUARDIAN'S SIGNATURE)

Date \_\_\_\_\_



# Maryville Orthopaedic Clinic

Patient Name \_\_\_\_\_ Reviewed \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ Date \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Age \_\_\_\_\_

If you have completed this form before and there have been no changes, check here   
 If you have completed this form before and there have been changes, check here and mark only the changes

<b>PAST MEDICAL HISTORY</b> Have you had any medical problems?      None <input type="checkbox"/> <table style="width:100%; border-collapse: collapse;"> <tr><td>High Blood Pressure</td><td>Yes</td><td>No</td></tr> <tr><td>Heart Disease</td><td>Yes</td><td>No</td></tr> <tr><td>Stroke</td><td>Yes</td><td>No</td></tr> <tr><td>Obstructive Pulmonary Disease</td><td>Yes</td><td>No</td></tr> <tr><td>Kidney Disease</td><td>Yes</td><td>No</td></tr> <tr><td>Thyroid Disease</td><td>Yes</td><td>No</td></tr> <tr><td>AIDS/HIV</td><td>Yes</td><td>No</td></tr> <tr><td>Hepatitis</td><td>Yes</td><td>No</td></tr> <tr><td>Rheumatoid Arthritis</td><td>Yes</td><td>No</td></tr> </table>	High Blood Pressure	Yes	No	Heart Disease	Yes	No	Stroke	Yes	No	Obstructive Pulmonary Disease	Yes	No	Kidney Disease	Yes	No	Thyroid Disease	Yes	No	AIDS/HIV	Yes	No	Hepatitis	Yes	No	Rheumatoid Arthritis	Yes	No	<b>MEDICATIONS</b> Please list all medications you are currently taking including dietary supplements: None <input type="checkbox"/> _____ _____ _____ _____
High Blood Pressure	Yes	No																										
Heart Disease	Yes	No																										
Stroke	Yes	No																										
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Rheumatoid Arthritis	Yes	No																										
<b>PAST SURGICAL HISTORY</b> Please list any operations you have had: None <input type="checkbox"/> _____ _____	<b>ALLERGIES</b> List all drugs to which you are allergic: No known allergies <input type="checkbox"/> _____ _____																											

<b>REVIEW OF SYSTEMS</b>					
Do you have any of these symptoms? Please circle either Yes or No for each condition.					
<b>Constitutional</b>		<b>Eyes</b>		<b>Ear, Nose and Throat</b>	
Fever	Yes No	Decreased vision	Yes No	Loss of Hearing	Yes No
Weight loss/gain	Yes No	Cataracts	Yes No	Sinus problems	Yes No
<b>Heart</b>		<b>Lungs</b>		<b>Gastrointestinal</b>	
Chest pain	Yes No	Shortness of breath	Yes No	Stomach Pain	Yes No
Irregular heart beat	Yes No	Wheezing	Yes No	Diarrhea	Yes No
Poor circulation	Yes No	Persistent cough	Yes No	Persistent Vomiting	Yes No
<b>Genitourinary</b>		<b>Musculoskeletal</b>		<b>Skin</b>	
Bloody urine	Yes No	Joint swelling	Yes No	Rash	Yes No
Pain on urinating	Yes No	Arthritis	Yes No	Dryness of skin	Yes No
Unable to urinate	Yes No	Fractures	Yes No	<b>Endocrine</b>	
<b>Neurological</b>		<b>Psychiatric</b>		Thyroid problems	Yes No
Paralysis	Yes No	Depression	Yes No	Diabetes	Yes No
Frequent headaches	Yes No	Bipolar disease	Yes No	<b>Other</b>	
<b>Blood</b>		<b>Allergic</b>		Sleep Apnea	Yes No
Bleeding problems	Yes No	Allergies to foods	Yes No	Latex Allergy	Yes No
Previous blood transfusion	Yes No	Allergies to things other than Medicines	Yes No	Trouble w/Anesthesia	Yes No

Are you currently being treated for these conditions?      Yes      No

<b>SOCIAL HISTORY</b> Do you use tobacco?      No      Amount _____ Do you use alcohol?      No      Amount _____ Do you have or have you had a problem with chemical dependency?      Yes      No Are you pregnant?      Yes      No	<b>FAMILY HISTORY</b> Has anybody in your family had any of these conditions? <table style="width:100%; border-collapse: collapse;"> <tr><td>Bleeding Disorder</td><td>Yes</td><td>No</td></tr> <tr><td>Heart disease</td><td>Yes</td><td>No</td></tr> <tr><td>Stroke</td><td>Yes</td><td>No</td></tr> <tr><td>Cancer</td><td>Yes</td><td>No</td></tr> </table>	Bleeding Disorder	Yes	No	Heart disease	Yes	No	Stroke	Yes	No	Cancer	Yes	No
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