Advanced Orthopedics
Columbus Regional Health Network

For Office Use Only:
MRN#: _____

Legal Name: _____ **SSN:** _____ **Date:** _____ **DOB:** _____

Sex: M / F **Primary Care Provider:** _____ **Referred by:** _____

Home Address: _____
Address City ST Zip Code

Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

E-mail address: _____ **Insurance Name:** _____

Employer Name/Address: _____ _____

Emergency Contact:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Responsible Party if Different:

Name: _____ SSN: _____ DOB: _____

Reason for Visit:

1. What body part is affected? _____
2. Have you had any x-rays taken?_____ If YES where were they taken_____
3. Is the problem mild, moderate, or severe? _____
4. Does anything make the problem worse? _____
5. Does anything make the problem better? _____
6. When did the problem start? _____
7. Was there an injury? **Yes / No** If **YES** where did it occur? _____

Please briefly describe the problem, and how it started:

_____

_____

Past Medical History/Illness: (Check all that apply)

__ Asthma / COPD
__ High Blood Pressure
__ Liver Disease (Hepatitis)
__ Rheumatoid Arthritis
__ Blood Clots
__ Kidney Disease
__ Vascular Disease
__ Thyroid Disorder
__ Heart Attack
__ Stroke
__ Seizures
__ Diabetes
__ Gout
__ Heart Failure
__ HIV/AIDS
__ Cancer, Type/Stage: _____
__ Blood/Bleeding Problems
__ High Cholesterol
__ Stomach Ulcers

Past Surgery: (Check all that apply)

__ Heart Bypass
__ Prostate
__ Tendon/Ligament Repair
__ Tubal Ligation
__ Joint Replacement
__ Other: _____
__ Hernia
__ Fractures
__ Bowel Surgery
__ Gallbladder Removal
__ Appendectomy
__ Hysterectomy

Social History: (Circle Y or N)

Do you smoke? **Y / N** How much: _____ Have you ever smoked? **Y / N** How much: _____
Do you consume alcohol? **Y / N** How much: _____ Employment Status: **working, retired, disabled** Job: _____
Relationship Status: **single, married, divorced, widowed** Have Kids: **Y / N**

Circle Below:

Mother: Deceased (Yes or No) Age of death _____ Cause of death _____
Father: Deceased (Yes or No) Age of death _____ Cause of death _____

Family History: Who in your family has the following? (Please write M for Mother, F for Father)

____ Asthma
____ COPD
____ Diabetes
____ Kidney Failure
____ Heart Attack
____ Stroke
____ High Cholesterol
____ High Blood Pressure
____ Glaucoma
____ Vascular Disease

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What pharmacy do you use? _____

Please list your medications and doses below: (Include any nonprescription medications)

_____

_____

Are you allergic to any medications? Yes or No

Please list medication allergies and your reaction: Nausea / itching / hives / difficulty breathing / other

_____

_____

Any allergy to: Iodine **Y / N** Metal **Y / N** Latex **Y / N**

Review of Systems: (Please check all that apply)

☐ **All below systems have been reviewed and all are negative except for chief complaint**

Constitutional: ☐fever, ☐chills, ☐sudden weight loss;

Ear, Nose, Throat: ☐deafness, ☐sinusitis, ☐hoarseness, ☐vertigo, ☐tinnitus;

Cardiovascular: ☐chest pain, ☐palpitation, ☐irregular heartbeat, ☐murmur;

Respiratory: ☐shortness of breath, ☐chronic cough;

Digestive: ☐diarrhea, ☐bleeding, ☐change in bowel habits, ☐reflux/heartburn;

Urologic: ☐bleeding, ☐incontinence;

Skin: ☐rash, ☐lesions that do not heal, ☐change in moles;

Neurological: ☐loss of balance/coordination, ☐paralysis;

Blood and Lymphatic System: ☐anemia, ☐bleeding tendencies;

Musculoskeletal: ☐stiffness, ☐joint pain, ☐muscle pain;

Authorization, Assignment of Benefits, and Referral Medical Release:

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly o Columbus Regional Health Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: _____ Date: _____

Request for Treatment:

The Group maintains personnel and facilities to assist my physicians in providing my medical care, and I authorize the Group personnel to perform the care ordered by my physicians. I understand that I have the right to be informed by the physicians of the nature and purpose of an proposed procedure and any available alternative methods of treatment, together with an explanation of the risk associated with each procedure. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice, and I acknowledge that the Group and its personnel are responsible for providing this information.

Signed: _____ Date: _____

Thank you!

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I, the undersigned, do hereby consent and request that Advanced Orthopedics communicate with or release health information concerning me if said communication is in my best interest and is only information that is directly relevant to designated individuals' involvement with my healthcare and treatment decisions.

Patient's name: x_____

Date of birth: x_____

-If you do not wish for anyone aside from healthcare professionals to have access to your treatment information, please check here:

-I do not grant consent for anyone to be given information regarding my care or treatment except required by law- ☐

1. Name and address of person who I want to have health information as outlined above

Name _____ Relationship to Patient _____

Address: _____

_____

Phone: _____

2. Name and address of person who I want to have health information as outlined above

Name _____ Relationship to Patient _____

Address: _____

_____

Phone: _____

3. Name and address of person who I want to have health information as outlined above

Name _____ Relationship to Patient _____

Address: _____

_____

Phone: _____

_____ _____

Signature Print