ROCHESTER COMMUNITY ORTHOPAEDICS, LLP

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Patient Information

Last Name:_____ First Name:_____ MI____

Date Of Birth:_____ Age:_____ Sex:_____ Marital Status:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Cell Phone Number:_____ Home Phone Number:_____

E-mail Address:_____

Contact Preference: Cell Phone Home Phone Mail Portal Work Phone E-mail Text

Employer:_____ Occupation:_____

Work Phone Number:_____

Preferred Language:_____ Ethnicity: ☐ White ☐ African-American ☐ Hispanic ☐ Asian ☐ Native American ☐ Other ☐ Decline

Emergency Contact:_____ Relationship:_____

Phone Number:_____

Who is your Primary Care Physician:_____

Are there any other Doctors you would like a report sent to:_____

What Pharmacy do you use:_____

How were you referred to this office:_____

Health Insurance Information

PRIMARY Insurance Company:_____

Contract No.:_____

Subscriber Name:_____ Relation To Patient:_____

Subscriber Date of Birth:_____

SECONDARY Insurance Company:_____

Contract No.:_____

Subscriber Name:_____ Relation To Patient:_____

Subscriber Date of Birth:_____

Authorizations:

I understand that I will be held responsible for payment for services not covered by my insurance.

I consent to the use or disclosure of my protected health information (PHI) by Rochester Community Orthopaedics, LLP for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Rochester Community Orthopaedics, LLP, and for such other uses that are permitted or required under federal or state law. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidence by my signature on this document.

Medicare: The information given by me in applying for payment under Title XVIII of the Social Security Administration Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its carriers, any information required to process my Medicare claims for payment purposes.

_____ _____

Signature **Date**

Relationship To Patient: _____
(If other than patient)

Please fill out this section if the patient is less than 18 years of age:

Father's Name:
_____

DOB:_____

Address:
_____

City:_____State:_____Zip:_____

Phone Number:_____

Mother's Name:
_____

DOB:_____

Address:
_____

City:_____State:_____Zip:_____

Phone Number:_____

Medical History

Patient Name: _____

Height_____ **Weight**_____ BMI:_____

List Medical Problems You Have or Had:

_____
_____
_____
_____
_____

List All Medications You Take

_____
_____
_____
_____
_____

List Surgeries You Have Had

_____
_____

List Allergies to Medications

_____
_____

Can you take Anti-inflammatory Drugs (Ibuprofen, Aleve, Aspirin)? **YES** **NO**

List Any Medical Problems in Your Family

_____
_____
_____

What Hobbies Do You Have?_____
Do You Play Any Sports Regularly?_____
Do You Exercise?_____

Please Mark the Appropriate Answer:

Yes	No	
☐	☐	Weight loss or Gain
☐	☐	Wound healing problems
☐	☐	Psoriasis
☐	☐	Depression
☐	☐	Blood clots
☐	☐	Bleeding Problems
☐	☐	Heart attack
☐	☐	High blood pressure
☐	☐	Stroke
☐	☐	Sciatica
☐	☐	Diabetes
☐	☐	Cancer
☐	☐	Drink Alcohol
☐	☐	Pneumonia Vaccine
☐	☐	Flu Vaccine

Yes	No	
☐	☐	Asthma
☐	☐	Pneumonia
☐	☐	Stomach Ulcers
☐	☐	Acid Reflux
☐	☐	Prostate problems
☐	☐	Urinary infections
☐	☐	Fibromyalgia
☐	☐	Gout
☐	☐	Hepatitis
☐	☐	AIDS
☐	☐	Osteoporosis
☐	☐	Taken Prednisone
☐	☐	Use Recreational Drugs
☐	☐	Colon Screening (Colonoscopy)

Tobacco Use: ☐Never ☐Former ☐Occasional ☐Everyday ☐ Light ☐Heavy

Signature:_____ **Date:**_____

CURRENT MEDICAL PROBLEM

Body Part:_____ ☐ **LEFT** ☐**RIGHT**

Please give us a ***description*** of the problem that brings you here for diagnosis and treatment:

_____

_____

Yes	No	
☐	☐	Is this problem related to a specific injury? Date of injury:_____
☐	☐	Is this problem related to a work injury?_____ Employer at time of injury:_____
☐	☐	Is this problem related to a motor vehicle accident? Date of accident:_____
☐	☐	Have you missed work because of this problem? When was the last day you worked?_____
☐	☐	Have you seen another doctor for this problem? Who and when:_____
☐	☐	Have you had any x-rays, MRI, or CT scans done? When and where:_____

(TO BE FILLED OUT BY PHYSICIAN)

Patient Age R / L Handed

- Location
- Duration d / w / m / y
- Injury
- Quality ache / sharp / dull
- Severity 1……5……10
- Timing day / night / work
- Context progressing / improving / no change

Previous

- Modifying Factors

PT / HEP

Meds
Injection
Brace

- Associated Sx