The Orthopaedic Specialists of South Texas

INNOVATIVE. EXCELLENT. CARE.

Date: ___ / ___ /___ ☐ New Patient ☐ Current Patient

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (Middle) _____

Social Security Number _____-_____-_____ Sex: ☐Male ☐Female Birthday: (Month/Day/Year) _____

Marital Status: ☐Single ☐Married ☐Divorced Name of spouse: _____ Spouse's Birthday (Month/Day/Year) _____

Address: _____City: _____State: _____ ZIP: _____

Home Phone: ( ) _____-_____ Work Phone ( ) _____-_____ Cell Phone: ( ) _____-_____

Email Address: _____

Referring Physician: _____ Office Phone: ( ) _____-_____

***State the reason for your visit today:** _____

***Date of Injury: (Month/Day/Year)** _____ ☐Personal Injury ☐Auto Accident ☐Work Injury

Employer Name: _____

Employer Address: Address: _____City: _____State: _____ ZIP: _____

Do you live in a skilled nursing facility or rehabilitation unit? ☐Yes ☐No If yes, please provide the following information:

Facility Name: _____ Phone ( ) _____-_____

Facility Address: _____City: _____State: _____ ZIP: _____

IN CASE OF EMERGENCY

Who may we call in case of Emergency? Name: _____Relation to patient: _____

Home Phone: ( ) _____-_____ Work Phone ( ) _____-_____ Cell Phone: ( ) _____-_____

BILLING INFORMATION

Name of person responsible for bill (Guarantor) _____

Social Security Number _____-_____-_____ Birthday: (Month/Day/Year) _____

ADDRESS SAME AS PATIENT ☐Yes ☐No If no, list Address: _____ City:_____ State:____ ZIP:_____

Home Phone: ( ) _____-_____ Work Phone ( ) _____-_____ Cell Phone: ( ) _____-_____

Employer of Guarantor: _____

Employer Address: _____City: _____State: _____ ZIP: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Secondary Insurance Carrier (If Applicable): _____

Patient Signature _____ **Date** _____

MEDICAL HISTORY

Name: (Last) _____ (First) _____ (Middle) _____

1. Medical Problems:
   Do you have:
   High Blood Pressure ☐ No ☐ Yes ☐ Unsure

   Diabetes ☐ No ☐ Yes ☐ Unsure

   Please list any other medical conditions you may have: _____

   _____

   _____

2. Review of Systems:
   Do you suffer from:

Chest Pain ☐ No ☐ Yes	Fever ☐ No ☐ Yes
Shortness of breath ☐ No ☐ Yes	Chills ☐ No ☐ Yes
Gastrointestinal or Urologic problems ☐ No ☐ Yes	Open Wound ☐ No ☐ Yes
Unintended weight loss ☐ No ☐ Yes	Drainage ☐ No ☐ Yes

   Please list any other medical conditions you may have:_____

   _____

   _____

3. List any surgeries you have had: _____

   Did you have any complication with anesthesia? ☐ No ☐ Yes

4. Last Tetanus: ☐ Less than 5 years ago ☐ More than 5 years ago

5. Medications:
   Are you taking blood thinners? ☐ No ☐ Yes

   Please list any other medications you are taking:

   _____

   _____

   Do you have any drug allergies? ☐ No ☐ Yes ☐ Unsure
   If yes, please list:

   _____

   _____

6. Do you smoke? ☐ No ☐ Yes If yes, how many years? _____ How much? _____

7. Do you drink alcohol? ☐ No ☐ Yes If yes, how much?
   _____

8. Is there any family history of anesthetic complication? ☐ No ☐ Yes

9. Please list any family medical problems: _____