# ORTHOPEDIC CENTER OF THE DAKOTAS

**WHO ARE YOU SCHEDULED TO SEE TODAY? CHECK ONE:**

❏ J.B. MacDougall, M.D. ❏ M.C. Reynen, M.D. ❏ D.J. Frisco, M.D.
❏ J.K. Mantone, M.D. ❏ P.J. Miller, M. D. ❏ D.A. Wolfgram, M.D.

The following information is very important to your health. Please take the time to fully and accurately fill out this form. Please fill out with black ink.

**PATIENT INFORMATION** **(PLEASE PRINT)** Chart # ____________

Patient Name ________________________________
Mailing Address ________________________________
________________________________
City, State, Zip ________________________________
Area Code/Phone No. ________________________________
Cell Phone No. ________________________________
Email Address ________________________________
Social Security No. ________________________________
Patient Sex M F Birthdate ___________ Age ____
Marital Status S M D W O Student Status (P-F)

Patient Employer ________________________________
Patient Occupation ________________________________
Address ________________________________
City, State, Zip ___________________ Phone _________
Employment Status Full-Time ______ Part-Time ______

Referring Physician ________________________________
Clinic ________________________________
City, State, Zip ________________________________

Emergency Contact (not living with you) ____________________
Emergency Phone ________________________________
Relation to Patient ________________________________

**Party Responsible for Payment of Personal Balance** (If patient is under the age of 18)

Guarantor Information Same As Above ❏
Guarantor Name ________________________________
Address ________________________________
City, State/Zip Code ________________________________
Guarantor Area Code/Phone No. ____________________

Patient Relationship to Guarantor ________________
Guarantor Employer ________________________________
Address ____________________ Phone _________
Guarantor Social Security No. ____________________
Guarantor Birthdate ___________________ Sex ______

**Spouse's Information** (if applicable)

Name ____________________________ Social Security No. ______________________ Birthdate ________________
Employer Name ________________________________ Occupation ________________________________
Street, City, State, Zip ________________________________ Area Code/Phone No. ________________________

| | | |
|---|---|---|
| **ARE YOU ELIGIBLE FOR ANY VETERAN'S BENEFITS?** | ❏ YES | ❏ NO |
| **ARE YOU ELIGIBLE FOR INDIAN HEALTH BENEFITS OR A MEMBER OF A NATIVE AMERICAN TRIBE?** | ❏ YES | ❏ NO |
| **ARE WE SEEING YOU FOR A WORK RELATED INJURY TODAY?** | ❏ YES | ❏ NO |
| **IF YES, HAVE YOU FILED A FIRST REPORT OF INJURY WITH YOUR EMPLOYER?** | ❏ YES | ❏ NO |
| **ARE WE SEEING YOU FOR A LIABILITY OR MOTOR VEHICLE ACCIDENT TODAY?** | ❏ YES | ❏ NO |
| **IF YES, HAVE YOU FILED A CLAIM WITH YOUR LIABILITY OR MOTOR VEHICLE INSURANCE?** | ❏ YES | ❏ NO |
| **IF MEDICARE PATIENT ARE YOU OR SPOUSE CURRENTLY EMPLOYED?** | ❏ YES | ❏ NO |
| **IF YES, DOES THE EMPLOYER HAVE MORE THAN 20 EMPLOYEES?** | ❏ YES | ❏ NO |

**Insurance Information- PLEASE PRESENT YOUR INSURANCE CARD TO BE SCANNED BY THE RECEPTIONIST**

**Primary Insurance**

Name of Insurance Company ____________________
Name of Policy Holder ________________________
Policy Holder Social Security No. ________________
Policy Holder Birthdate ________________________
Relationship to Patient ________________________

**Secondary Insurance**

Name of Insurance Company ____________________
Name of Policy Holder ________________________
Policy Holder Social Security No. ________________
Policy Holder Birthdate ________________________
Relationship to Patient ________________________

(SEE BACK FOR MORE INFORMATION)

# PATIENT'S MEDICAL HISTORY

Date of Birth: ____________ Height: _________ Weight: _________ Family Pharmacy: ____________________

Referring Physician____________________________ Family Doctor: ____________________________

Description of Problem: ❑ Right ❑ Left ______________________________ Date of Injury:____________

How Did Injury Occur:________________________________________________________________

Current Medications/Vitamins: (including aspirin and herbal supplements) ____________________________

________________________________________________________________________________

Medical Allergies:______________________ Previous Orthopedic Injuries:______________________

Previous Surgeries of any kind:
❑ Appendectomy ❑ Gall Bladder ❑ Pacemaker ❑ Bypass ❑ Hernia Repair ❑ Tonsils ❑ C-Section ❑ Hysterectomy ❑ Cataract
❑ Orthopedic ________________________________ ❑ Other ________________________________

| SOCIAL HISTORY: | | | If yes, how many? | How Long? | FAMILY HISTORY OF ILLNESS/DISEASE: (cancer, diabetes, etc.) |
|---|---|---|---|---|---|
| Alcohol Use? | ❑ Yes | ❑ No | _______ | ______ | ________________________________ |
| Tobacco Use? | ❑ Yes | ❑ No | _______ | ______ | ________________________________ |

Any Likelihood of Current Pregnancy? ❑ Yes ❑ No

**PATIENT** REVIEW OF SYSTEMS: Are you now or have you ever been treated for any of the following:

**INTEGUMENTARY:**
- Skin Ulcers ❑ Yes ❑ No
- Skin Disease ❑ Yes ❑ No
- Eczema ❑ Yes ❑ No
- Psoriasis ❑ Yes ❑ No

**EYES:**
- Glaucoma ❑ Yes ❑ No
- Blurred/Double Vision ❑ Yes ❑ No

**EARS, NOSE, THROAT & MOUTH (ENT):**
- Dizziness ❑ Yes ❑ No
- Sinus Infections ❑ Yes ❑ No
- Hearing Loss ❑ Yes ❑ No

**RESPIRATORY:**
- Asthma ❑ Yes ❑ No
- Tuberculosis ❑ Yes ❑ No
- Shortness Breath ❑ Yes ❑ No
- Emphysema ❑ Yes ❑ No
- Recent Cold/Flu ❑ Yes ❑ No
- **Home Oxygen** ❑ Yes ❑ No
- **Sleep Apnea/CPAP** ❑ Yes ❑ No

**CARDIOVASCULAR:**
- **High Blood Pressure** ❑ Yes ❑ No
- **Heart Disease** ❑ Yes ❑ No
- **Vascular Disease** ❑ Yes ❑ No
- **Heart Attack** ❑ Yes ❑ No
- **Chest Pain** ❑ Yes ❑ No
- **Stress Test** ❑ Yes ❑ No
  Year ______ Where____________

**GASTROINTESTINAL:**
- Gallbladder Disease ❑ Yes ❑ No
- Liver Disease ❑ Yes ❑ No
- Ulcers ❑ Yes ❑ No

**GENITOURINARY:**
- Kidney Disease ❑ Yes ❑ No
- Lower Side Pain ❑ Yes ❑ No
- Burning w/urination ❑ Yes ❑ No
- Kidney Stone ❑ Yes ❑ No

**MUSCULOSKELETAL:**
- Gout ❑ Yes ❑ No
- **Arthritis** ❑ Yes ❑ No
- **Rheumatoid Arthritis** ❑ Yes ❑ No
- Joint Stiffness ❑ Yes ❑ No
- Muscle Weakness ❑ Yes ❑ No

**NEUROLOGICAL:**
- Seizures ❑ Yes ❑ No
- Numbness/Weakness ❑ Yes ❑ No
- Severe/Frequent Headache ❑ Yes ❑ No
- **Stroke** ❑ Yes ❑ No

**PSYCHIATRIC:**
- Depression ❑ Yes ❑ No
- Anxiety ❑ Yes ❑ No

**ENDOCRINE:**
- Thyroid Disease ❑ Yes ❑ No
- Diabetes ❑ Yes ❑ No

**HEMATOLOGIC/LYMPHATIC:**
- Hepatitis ❑ Yes ❑ No
- Blood Clots ❑ Yes ❑ No
- Cancer ❑ Yes ❑ No
- Easy Bruising/bleeding ❑ Yes ❑ No

**ALLERGIC/IMMUNOLOGIC:**
- Hives ❑ Yes ❑ No
- Rash Present ❑ Yes ❑ No
- Immune System Disorder ❑ Yes ❑ No

If yes to any of the above please explain:____________________________________________

PHYSICIAN USE: ❑ Reviewed – No Changes ❑ Additional Comments:

________________________________________________________________________________

Physician Signature: ______________________________ Date:______________________

**Authorization:** I hereby authorize the physician to furnish any and all information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original. I hereby acknowledge that I have received a copy of the Orthopedic Center of the Dakotas Notice of Privacy Practices.

______________________________ ______________________________

Signature Date