

Date _____

PATIENT REGISTRATION

THE INDIANA ORTHOPAEDIC CENTER

Acct. # _____

Doctor _____

PATIENT INFORMATION

NAME: _____ Male Female
FIRST MIDDLE LAST

ADDRESS: _____
STREET APT#

CITY STATE ZIP

HOME PHONE BIRTHDATE AGE SOCIAL SEC. #

EMPLOYED BY OCCUPATION DOMINANT HAND -- RIGHT OR LEFT

EMPLOYER'S ADDRESS BUSINESS PHONE EXT.

NEAREST FRIEND OR RELATIVE (Not living with patient) RELATIONSHIP TO PATIENT HOME PHONE

Referred by (circle one): Referring Dr. Family Dr. Family/Friend Yellow Pages Insurance Co. Newspaper

Family Physician _____ Address _____ phone _____

Referring Dr. _____ Address _____ phone _____

Part of Body injured or affected: _____

Were you injured? Y N If yes, how were you injured? _____

Date of Injury: _____ Date of first symptoms: _____

Have you had any previous orthopaedic problems or surgeries? _____

Height _____ Weight _____ Have you retained an attorney for this injury/accident? Y N

Is this complaint work related? Y N Is this injury a result of an auto accident? Y N Did you file a first report of injury? Y N

| ALLERGIES: | MEDICATIONS you are now taking: | SURGERIES | YEAR |
|------------|---------------------------------|-----------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

SOCIAL HISTORY:

Do you smoke? Y N How many daily? _____ Recreational Drug Use? Y N

Alcohol Consumption? Y N # Drinks/week _____ Have you ever taken steroids/cortisone? Y N

PLEASE CIRCLE ANY ILLNESSES YOU HAVE HAD:

| | | | | |
|----------------------|------------------|-----------------------|----------------------|------------------|
| Anesthetic Reactions | Eczema/Psoriasis | Hepatitis | Neuritis | Tuberculosis |
| Asthma | Emphysema | High blood pressure | Pancreatitis | Ulcers (leg) |
| Bowel Disease | Epilepsy | Kidney disease | Respiratory disease | Ulcers (stomach) |
| Bronchitis | Eye disease | Liver disease | Rheumatic fever | Venereal disease |
| Bleeding tendencies | Glaucoma | Measles | Rheumatoid arthritis | HIV |
| Cancer-tumors | Gout | Mitral valve prolapse | Stomach trouble | Other: _____ |
| Diabetes | Heart disease | Mumps | Stroke | _____ |
| Diverticulitis | Hemorrhoids | Nervous breakdown | Thyroid disease | _____ |

FAMILY HISTORY — PLEASE CIRCLE ANY CONDITION OCCURRING ON EITHER SIDE OF PATIENT'S FAMILY:

| | | | |
|-----------------|--------------------------|---------------------|-----------------------|
| Allergies | Heart disease | Kidney disease | List other illnesses: |
| Arthritis | Congenital deformities | Thyroid disease | _____ |
| Bone disease | Diabetes | Tuberculosis | _____ |
| Blood Disease | Gastrointestinal disease | Bleeding tendencies | _____ |
| Cancer - tumors | Mental disease | | _____ |

*** MORE INFORMATION ON BACK ***

