

Date _____

PATIENT REGISTRATION

THE INDIANA ORTHOPAEDIC CENTER

Acct.# _____

Appt. Date _____

Doctor _____

NAME: _____ Male Female
FIRST MIDDLE LAST

ADDRESS: _____
STREET APT #

CITY STATE ZIP E-MAIL

HOME PHONE CELL PHONE V/M ALLOWED? BIRTHDATE AGE SOCIAL SEC #

EMPLOYED BY OCCUPATION DOMINANT HAND - RIGHT OR LEFT

EMPLOYER'S ADDRESS BUSINESS PHONE EXT.

EMERGENCY CONTACT (Not living with patient) RELATIONSHIP TO PATIENT HOME PHONE

REFERRED BY _____

FAMILY DR _____ ADDRESS PHONE

Part of Body injured or affected: _____ DATE OF INJURY OR ONSET

Were you injured? _____ IF YES, HOW WERE YOU INJURED? HEIGHT WEIGHT

Is this complaint work related? _____ Is this injury a result of an auto accident? _____

Have you had any previous orthopaedic problems? _____

ALLERGIES:	MEDICATIONS and DOSAGES: (List both prescribed and over the counter)	SURGERIES	YEAR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you smoke? _____ How many daily? _____ Recreational Drug Use? _____ Immunizations Current? _____

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

PLEASE CHECK ANY ILLNESSES YOU HAVE HAD:

Anesthetic Reactions Asthma Bowel Disease
 Cancer Diabetes Fibromyalgia
 Gout Heart disease Hepatitis
 High blood pressure HIV Kidney disease
 Liver disease Neuritis Pancreatitis
 Respiratory disease Rheumatoid arthritis Stroke
 Tuberculosis None

Explain: _____

FAMILY HISTORY - PLEASE CHECK ANY CONDITION OCCURRING ON EITHER SIDE OF PATIENT'S FAMILY:

Allergies Arthritis Bone disease
 Bleeding tendencies Blood disease Blood clots
 Congenital deformities Cancer - tumors Diabetes
 Gastrointestinal disease Heart disease Kidney disease
 Mental disease Thyroid disease Tuberculosis
 None

Other illnesses: _____

REVIEW OF SYSTEMS - PLEASE CHECK ANY RECENT OCCURRENCES

Back Pain Blood in Urine Burning or Pain During Urination Change in Appetite Chest Pain Or Discomfort
 Constipation Cough(dry or wet,productive) Decreased Hearing Depression Diarrhea
 Dizziness Ease of Bleeding Ease of Bruising Eye Pain Eye Redness
 Fainting Fatigue Fever or Chills Frequent Urination Hair and Nail Changes
 Head Injury History of Blood Clots Incontinence Leg Cramping Loose Teeth
 Lumps Muscle Stiffness Nausea Neck Pain Neck Stiffness
 Nervousness Nosebleeds Rashes Rectal Bleeding Seizures
 Shortness of Breath STD's Swallowing Difficulties Swelling Tingling
 Weakness Weight Loss Or Gain Wheezing None

PARENT OR SPOUSE INFORMATION

NAME: _____ **Male** **Female**
FIRST MIDDLE LAST

ADDRESS: _____
(IF NOT SAME AS ABOVE) STREET CITY STATE ZIP

SOCIAL SEC. # HOME PHONE BIRTHDATE

SPOUSE EMPLOYED BY OCCUPATION

EMPLOYER'S ADDRESS BUSINESS PHONE

INSURANCE INFORMATION

1. * WE NEED TO COPY YOR INSURANCE CARD AND DRIVERS LICENSE.

** If you do not have your insurance card at the time of your visit, you will be responsible for filing your own insurance.*

PRIMARY COVERAGE

SECONDARY COVERAGE

NAME OF INSURANCE

NAME OF INSURANCE

ADDRESS/PHONE

ADDRESS/PHONE

POLICYHOLDER'S NAME INSURED'S DOB

POLICYHOLDER'S NAME INSURED'S DOB

NAME OF EMPLOYER

NAME OF EMPLOYER

ID #

ID #

POLICY # GROUP

POLICY # GROUP

INSURED'S SS#

INSURED'S SS#

EFFECTIVE DATE

EFFECTIVE DATE

PHARMACY NAME: _____ ID: _____ PHONE: _____

PHARMACY ADDRESS: _____

Patient/Guardian Signature: _____

Form completed by: _____