



Dr. Kurtis Staples

Dr. Gilbert Ortega

Dr. Laura Prokuski

Dr. Brian Miller

Dr. Michael Billhymmer

Dr. Thomas Fishler

Dr. Heather Woodin

Today's Date:				PCP:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:		Marital status:		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		Former name:		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Address:							
Social Security #:		Home phone #:			Cell phone #:		
Occupation:		Employer:		Employer phone #:			
Email Address:		Married: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse's Name:		Race of Patient:			
How were you referred to Sonoran Orthopaedic Trauma Surgeons? <input type="checkbox"/> Internet <input type="checkbox"/> Referral from friend/family (Name: _____) <input type="checkbox"/> Referral from another provider (Provider Name: _____) <input type="checkbox"/> Emergency Department <input type="checkbox"/> Insurance list of providers <input type="checkbox"/> Advertisement <input type="checkbox"/> Other:					Preferred Language of Patient <input type="checkbox"/> English <input type="checkbox"/> Spanish If other:		
Other family members seen here:							
<i>In compliance with the American Recovery and Reinvestment Act of 2009 (AARA) to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.</i>							
MEDICARE PATIENTS ONLY							
Do you currently reside in a Skilled Nursing Facility? <input type="checkbox"/> Yes <input type="checkbox"/> No							
INSURANCE INFORMATION (Please give your insurance card to the receptionist.)							
Person responsible for bill:	Birth date:	Address (if different):			Home phone #:		
Is this person a patient here?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is this patient covered by insurance?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Occupation:	Employer:	Employer address:			Employer phone #:		
Please indicate primary insurance:							
Subscriber's name:		Subscriber's S.S. #.:	Birth date:	Group #:	Policy #:	Co-payment: \$	
Patient's relationship to subscriber:							
Name of secondary insurance (if applicable):			Subscriber's name:		Group #:	Policy #:	
Patient's relationship to subscriber:							
IN CASE OF EMERGENCY							
Name of local friend or relative (not living at same address):			Relationship to patient:	Home phone #:	Work phone #:		
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sonoran Orthopaedic Trauma Surgeons or insurance company to release any information required to process my claims.							
_____ Patient/Guardian signature				_____ Date			

Today's Date:

PATIENT INFORMATION

Patient's last name:

First:

Middle:

Marital status:

Is this your legal name?

If not, what is your legal name?

Former name:

Birth date:

Age:

Sex:

Yes No

M F

HISTORY OF PRESENT ILLNESS

What body part is involved? (please check all that apply below)

Ankle: R L Arm: R L Back: Elbow: R L Finger: _____ R L Foot: R L

Hand: R L Hip: R L Knee: R L Leg: R L Neck: R L Pelvis:

Shoulder: R L Toe: R L Wrist: R L Other: _____

How long ago did this problem start? (Please list number and select duration) _____ Days Weeks Months Years

Were you in the ER for this problem? Yes No

Which ER? _____

Do you have the following? Bruising Joints Giving Way Hands Feeling Clumsy Locking/Catching Weakness Numbness Poor Balance

Loss of Control of Bladder Tingling Swelling

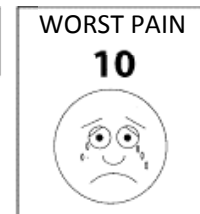
Current problem is a result of:

Car Accident? Yes No Work Accident? Yes No Other (Specify): _____

What is your pain level today?



1 **2** **3** **4** **5** **6** **7** **8** **9**



MEDICARE PATIENTS ONLY

Do you currently reside in a Skilled Nursing Facility? Yes No

PAST OPERATIONS / HOSPITALIZATIONS

Please list any operations or hospitalizations you have had, the year, surgeon and city they took place.

Type	Year	Surgeon	City

SOCIAL HISTORY

Have you used any of the following substances?

Substance	Currently Use?	Previously Used?	Type/Amount/Frequency	How long? (Years)	If stopped, when? (Year)
Caffeine: coffee, tea, soda	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Tobacco	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Alcohol: beer, wine, liquor	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes			
Recreational/Street drugs	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes			

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sonoran Orthopaedic Trauma Surgeons or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

MEDICAL HISTORY (ARE YOU CURRENTLY RECEIVING TREATMENT OR HAVE YOU RECEIVED TREATMENT IN THE PAST FOR ANY OF THE FOLLOWING CONDITIONS?)							
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary Embolism	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gallbladder Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Birth Defects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke/TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bladder Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	MRSA/Staph Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding or Bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer Type	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Peripheral Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer Type	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No		
DVT/Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Intestinal/Bowel Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychological problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		
FINANCIALLY RESPONSIBLE PERSON (IF DIFFERENT FROM ABOVE)							
	Birth date:	Address (if different):			Home phone #:		
Is this person a patient here?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Is this patient covered by insurance?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Occupation:	Employer:	Employer address:			Employer phone #:		
Please indicate primary insurance:							
Subscriber's name:	Subscriber's S.S. #:	Birth date:	Group #:	Policy #:	Co-payment: \$		
Patient's relationship to subscriber:							
Name of secondary insurance (if applicable):			Subscriber's name:		Group #:	Policy #:	
Patient's relationship to subscriber:							
Name of local friend or relative (not living at same address):			Relationship to patient:	Home phone #:	Work phone #:		
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sonoran Orthopaedic Trauma Surgeons or insurance company to release any information required to process my claims.							
_____ Patient/Guardian signature				_____ Date			