SONORAN ORTHOPAEDIC
TRAUMA SURGEONS

# Patient Demographics

Dr. Anthony Rhorer | Dr. Gilbert Ortega | Dr. Laura Prokuski | Dr. Brian Miller
Dr. Kurtis Staples | Dr. Michael Billhymer | 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? ☐ Yes ☐ No | If not, what is your legal name? | Former name: | Birth date: | Age: | Sex: ☐ M ☐ F |
|---|---|---|---|---|---|

Address:

| Social Security #: | Home phone #: | Cell phone #: |
|---|---|---|
| Occupation: | Employer: | Employer phone #: |
| Email Address: | Married: ☐ Yes ☐ No<br>Spouse's Name: | Race of Patient: |

| How were you referred to Sonoran Orthopaedic Trauma Surgeons? | Preferred Language of Patient |
|---|---|
| ☐ Internet ☐ Referral from friend/family (Name: )<br>☐ Referral from another provider (Provider Name: ) ☐ Emergency Department<br>☐ Insurance list of providers ☐ Advertisement ☐ Other: | ☐ English ☐ Spanish<br>If other: |

Other family members seen here:

*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 andethnicity.*

**MEDICARE PATIENTS ONLY**

Do you currently reside in a Skilled Nursing Facility? ☐ Yes ☐ 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? | ☐ Yes ☐ No | Is this patient covered by insurance? | ☐ Yes ☐ 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? ☐ Yes ☐ No | If not, what is your legal name? | Former name: | Birth date: | Age: | Sex: ☐ 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

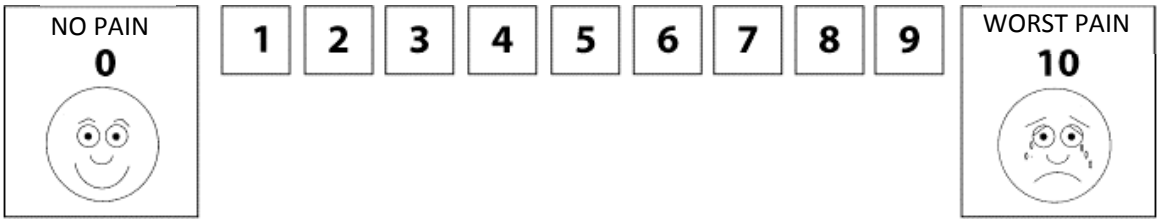
Which ER? _____

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?




**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 | ☐ No ☐ Yes | ☐ No ☐ Yes | | | |
| Tobacco | ☐ No ☐ Yes | ☐ No ☐ Yes | | | |
| Alcohol: beer, wine, liquor | ☐ No ☐ Yes | ☐ No ☐ Yes | | | |
| Recreational/Street drugs | ☐ No ☐ Yes | ☐ No ☐ Yes | | | |

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_____ _____

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 | ☐ Yes ☐ No | Epilepsy | ☐ Yes ☐ No | Kidney Problems | ☐ Yes ☐ No | Pulmonary Embolism | ☐ Yes ☐ No |
| Arthritis | ☐ Yes ☐ No | Gallbladder Problems | ☐ Yes ☐ No | Liver Disease | ☐ Yes ☐ No | Rheumatic Fever | ☐ Yes ☐ No |
| Asthma | ☐ Yes ☐ No | Gout | ☐ Yes ☐ No | Lung Problems | ☐ Yes ☐ No | Sexually Transmitted Disease | ☐ Yes ☐ No |
| Birth Defects | ☐ Yes ☐ No | Heart Disease | ☐ Yes ☐ No | Phlebitis | ☐ Yes ☐ No | Stroke/TIA | ☐ Yes ☐ No |
| Bladder Problems | ☐ Yes ☐ No | Hepatitis | ☐ Yes ☐ No | MRSA/Staph Infection | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No |
| Bleeding or Bruising | ☐ Yes ☐ No | HIV/AIDS | ☐ Yes ☐ No | Osteoporosis | ☐ Yes ☐ No | Thyroid Problems | ☐ Yes ☐ No |
| Cancer Type | ☐ Yes ☐ No | High Blood Pressure | ☐ Yes ☐ No | Peripheral Vascular Disease | ☐ Yes ☐ No | Ulcer Type | ☐ Yes ☐ No |
| Diabetes | ☐ Yes ☐ No | High Cholesterol | ☐ Yes ☐ No | Polio | ☐ Yes ☐ No | | |
| DVT/Blood Clots | ☐ Yes ☐ No | Intestinal/Bowel Problems | ☐ Yes ☐ No | Psychological problems | ☐ Yes ☐ No | | |

**FINANCIALLY RESPONSIBLE PERSON (IF DIFFERENT FROM ABOVE)**

| | | | |
|---|---|---|---|
| | Birth date: | Address (if different): | Home phone #: |
| Is this person a patient here? | ☐ Yes ☐ No | Is this patient covered by insurance? | ☐ Yes ☐ 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 #: |

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