SONORAN ORTHOPAEDIC
TRAUMA SURGEONS

Sonoran HIP CENTER
Subsidiary of Sonoran Orthopaedic Trauma Surgeons PLLC

Patient Demographics

GENERAL PATIENT INFORMATION

Date

Please check preferred contact number
1. ( ) CELL
2. ( ) HOME

Patient Last Name First Name Middle

ADDRESS APT/LOT# CITY STATE ZIP

SEX: M F

SS# DOB AGE

PRIMARY CARE PHYSICIAN

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER _____

REFERRED BY

EMPLOYED BY

WORK PHONE

OCCUPATION

EMAIL ADDRESS

SPOUSE OR SIGNIFICANT OTHER INFORMATION

NAME DATE OF BIRTH PHONE#

IN CASE OF EMERGENCY

NAME OF PERSON IN CASE OF EMERGENCY OTHER THAN SPOUSE RELATIONSHIP PHONE #

IF THE PATIENT IS A MINOR OR STUDENT

RESPONSIBLE PARTY RELATIONSHIP DOB PHONE #

ADDRESS CITY STATE ZIP SS#

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY POLICY HOLDERS NAME DOB PHONE

POLICY NUMBER GROUP NUMBER SS#

PATIENT RELATION TO POLICY HOLDER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____

SECONDARY INSURANCE

INSURANCE COMPANY POLICY HOLDERS NAME DOB PHONE

POLICY NUMBER GROUP NUMBER SS#

PATIENT RELATION TO POLICY HOLDER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____

IS YOUR CONDITION RELATED TO AN ACCIDENT OF ANY KIND? ☐ YES ☐ NO ☐ WORK RELATED ☐ AUTO ACCIDENT

OTHER (EXPLAIN) _____ DATE OF INJURY _____

DO YOU HAVE LEGAL ACTION PENDING REGARDING THIS INJURY? ☐ NO ☐ YES ATTORNEY NAME _____

IT IS YOUR RESPONSIBILITY TO PROVIDE YOUR INSURANCE COMPANY WITH ANY REQUESTED INFORMATION NEEDED TO PROCESS YOUR CLAIM. IF YOUR INSURANCE PLAN REQUIRES AUTHORIZATION FROM YOUR PRIMARY CARE PHYSICIAN IT IS **YOUR RESPONSIBILITY** TO HAVE THE AUTHORIZATION AT THE TIME OF YOUR VISIT. WITHOUT THE REQUIRED INFORMATION OR APPROPRIATE AUTHORIZATION, TODAY'S CHARGES MAY BE YOUR RESPONSIBILITY. I AUTHORIZE THE DOCTOR TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR THE PROPER MEDICAL CARE. I AUTHORIZE AND REQUEST SONORAN ORTHOPAEDIC TRAUMA SURGEONS (SOTS) TO RELEASE MY MEDICAL RECORDS TO ANY OTHER PHYSICIAN/MEDICAL FACILITIES DIRECTLY INVOLVED IN MY CARE AND FOR THE PURPOSE OF ADMINISTERING CLAIMS. I HAVE BEEN MADE AWARE OF SOTS NOTICE OF PRIVACY PRACTICES AND FINANCIAL POLICY. I HEREBY AUTHORIZE THE ASSIGNMENT OF PAYMENT OF MY MEDICAL BENEFITS TO SOTS. I UNDERSTAND I MAY RECEIVE SERVICES OR SUPPLIES THAT ARE NOT COVERED BY MY INSURANCE PLAN AND I AGREE TO BE DIRECTLY RESPONSIBLE FOR THESE EXPENSES. I UNDERSTAND COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. DELINQUENT ACCOUNTS MAY BE REFERRED TO A COLLECTION AGENCY FOR PAYMENT. ASSOCIATED COLLECTION AGENCY COSTS WILL BE YOUR RESPONSIBILITY.

PATIENT/PARENT/GUARDIAN SIGNATURE **DATE**

SONORAN ORTHOPAEDIC
TRAUMA SURGEONS

Sonoran HIP CENTER
Subsidiary of Sonoran Orthopaedic Trauma Surgeons PLLC

Health History

NAME | DOB | AGE | DATE

□ Right Handed □ Male
HT _____ WT_____ □ Left Handed □ Female

Reason for today's visit

Preferred Pharmacy Name | Address

Phone

ALLERGIES:

ARE YOU ALLERGIC TO ANY DRUGS? LIST ALL DRUG ALLERGIES INCLUDING REACTION.

ARE YOU ALLERGIC TO?			DRUG:	REACTION:
EGGS	□ YES	□ NO		
IODINE	□ YES	□ NO		
LATEX	□ YES	□ NO		
NUTS	□ YES	□ NO		
PENICILLIN	□ YES	□ NO		
OTHER				

CURRENT MEDICATIONS: LIST ALL, INCLUDE OVER THE COUNTER MEDS, HERBS AND VITAMINS

DRUG NAME/STRENGTH	DOSE	HOW LONG	PRESCRIBING PHYSICIAN

SURGICAL HISTORY: HAVE YOU UNDERGONE ANY SURGICAL PROCEDURES? □ YES □ NO

YEAR	SURGERY	YEAR	SURGERY

ANESTHESIA: HAVE YOU EVER HAD ANY PROBLEMS WITH ANESTHESIA? □ YES □ NO. IF YES, PLEASE EXPLAIN

ADVANCED DIRECTIVES: (LIVING WILL AND MEDICAL POWER OF ATTORNEY)

Do you have an advanced directive? ☐ YES ☐ NO

Would you like information or a copy of advance directive forms? ☐ YES ☐ NO

PATIENT NAME: _____

SONORAN ORTHOPAEDIC
TRAUMA SURGEONS

Sonoran HIP CENTER
Subsidiary of Sonoran Orthopaedic Trauma Surgeons PLLC

Health History

MEDICAL HISTORY: **HAVE YOU EVER HAD PROBLEMS WITH: (IF "YES", PLEASE CHECK BOX)**

☐ ALLERGIES	☐ CANCER	☐ HEPATITIS/JAUNDICE	☐ MENTAL ILLNESS	☐ SLEEP APNEA
☐ ANEMIA	☐ DEPRESSION	☐ HIGH BLOOD PRESSURE	☐ MIGRAINE HEADACHES	☐ STOMACH ULCERS
☐ ARTHRITIS	☐ DIABETES	☐ HIGH CHOLESTEROL	☐ MULTIPLE SCLEROSIS	☐ WOUND HEALING
☐ BIRTH DEFECT	☐ EMPHYSEMA	☐ HIV/AIDS	☐ NEUROLOGICAL PROBLEMS	☐ STROKE
☐ BLADDER	☐ EPILPSY OR SEIZURES	☐ KIDNEYS	☐ OLD FRACTURE	☐ TUBERCULOSIS
☐ BLEEDING DISORDER	☐ FIBROMYALGIA	☐ LIVER	☐ OSTEOMYELITIS	☐ THYROID DISEASE
☐ BLOOD CLOTS	☐ GOUT	☐ LUNGS	☐ POLIO	☐ SICKLE CELL

DESCRIBE ALL YES RESPONSES: _____

IF YOU ARE OVER THE AGE OF 50 HAVE YOU RECEIVED AN INFLUENZA (FLU) SHOT WITHIN THE LAST YEAR? ☐ YES ☐ NO

DATE: _____

IF YOU ARE OVER THE AGE OF 50 HAVE YOU RECEIVED A PNEUMONIA VACINATION? ☐ YES ☐ NO

DATE: _____

REVIEW OF SYSTEMS: ARE YOU CURRENTLY HAVE ANY PROBLEMS WITH: ***(IF "YES", PLEASE CHECK BOX'S)***

GENERAL:
- ☐ UNEXPECTED WEIGHT LOSS
- ☐ Weight gain
- ☐ Fever
- ☐ Fatigue
- ☐ Chills
- ☐ Other _____
- ☐ Check box if NO to all above

EYES:
- ☐ Blurred vision
- ☐ Double vision
- ☐ Corrective lens
- ☐ Eye pain
- ☐ Eye redness
- ☐ Watering
- ☐ Other _____
- ☐ Check box if NO to all above

ALLERGIC:
- ☐ Foods
- ☐ Dust
- ☐ Pollen
- ☐ Hay fever
- ☐ Other _____
- ☐ Check box if NO to all above

Heart:
- ☐ Chest pain
- ☐ Murmurs
- ☐ Fainting
- ☐ Palpitations
- ☐ Other _____
- ☐ Check box if NO to all above

LUNGS:
- ☐ SOB
- ☐ Snoring
- ☐ Coughing
- ☐ Wheezing
- ☐ Tightness
- ☐ Other _____
- ☐ Check box if NO to all above

STOMACH/COLON:
- ☐ Hear burn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody/tarry stools
- ☐ Other _____
- ☐ Check box if NO to all above

SKIN:
- ☐ Redness
- ☐ Rash
- ☐ Itching
- ☐ Poor healing
- ☐ Skin Changes
- ☐ Other _____
- ☐ Check box if NO to all above

MUSCLE/JOINTS:
- ☐ Joint pain
- ☐ Stiffness
- ☐ Joint swelling
- ☐ Redness
- ☐ Muscle pain
- ☐ Heat
- ☐ Joint instability
- ☐ Other _____
- ☐ Check box if NO to all above

NEUROLOGIC:
- ☐ Dizziness
- ☐ Tremors
- ☐ Unsteady gait
- ☐ Seizure
- ☐ Numbness/Tingling
- ☐ Other _____
- ☐ Check box if NO to all above

ENDOCRINE:
- ☐ Excessive thirst
- ☐ Heat/cold tolorance
- ☐ Excessive urination
- ☐ Other _____
- ☐ Check box if NO to all above

MENTAL HEALTH:
- ☐ Anxiety
- ☐ Nervousness
- ☐ Hallucinations
- ☐ Depression
- ☐ Other _____
- ☐ Check box if NO to all above

BLOOD:
- ☐ Easy bleeding
- ☐ Bruising
- ☐ Other _____
- ☐ Check box if NO to all above

DESCRIBE ALL YES RESPONSES: _____

PATIENT NAME: _____

SONORAN ORTHOPAEDIC
TRAUMA SURGEONS

Sonoran HIP CENTER
Subsidiary of Sonoran Orthopaedic Trauma Surgeons PLLC

Health History

FAMILY HISTORY:	MOTHER	FATHER	SIBLINGS		MOTHER	FATHER	SIBLINGS
Asthma	☐	☐	☐	Mental illness	☐	☐	☐
Bleeding Disorders	☐	☐	☐	Osteroarthritis	☐	☐	☐
Cancer	☐	☐	☐	Arthirits	☐	☐	☐
Diabetes	☐	☐	☐	Seizures	☐	☐	☐
DVT (Blood Clots)	☐	☐	☐	Sickle Cell	☐	☐	☐
Heart Disease	☐	☐	☐	Stroke	☐	☐	☐
High Blood Pressure	☐	☐	☐	Thyroid Disease	☐	☐	☐
Kidney Disease	☐	☐	☐	Other	☐	☐	☐

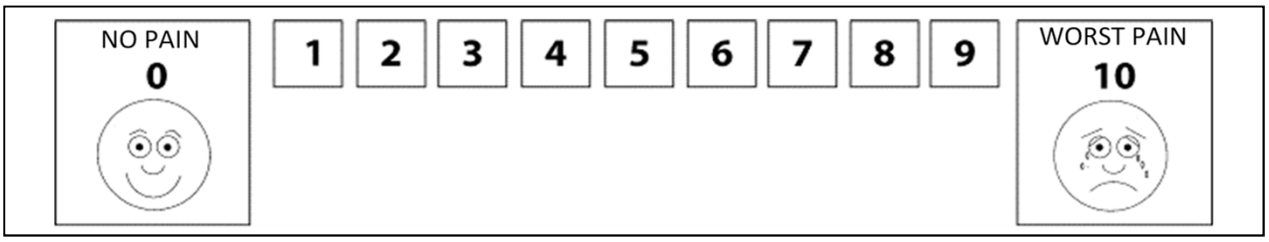
GIVE DETAILS TO "OTHER" AND ANY POSITIVE RESPONSES:

SOCIAL HISTORY:

Do you smoke tobacco?	☐ NO	☐ YES	_____ packs per day for _____ years
Did you quit smoking tobacco?	☐ NO	☐ YES	When did you quit? _____ Previous amount _____
Do you chew tobacco?	☐ NO	☐ YES	How Often? _____
Do you drink alcohol?	☐ NO	☐ YES	How much and How often? _____
Do you live alone?	☐ NO	☐ YES	Do you have children?_____ If yes, how many? _____
Do you use walking aids?	☐ NO	☐ YES	☐ Cane ☐ Walker ☐ Crutches ☐ Other
Do you have a history of substance abuse or do you use recreational drugs?	☐ NO	☐ YES	
	☐ NO	☐ YES	

Do you exercise? ☐ Never ☐ Rarely ☐ Weekly ☐ Daily Type: _____

WHAT IS YOUR PAIN LEVEL TODAY?



Medicare Patients Only

Do you reside in a Skilled Nursing Facility? ☐ No ☐ YES

Patient Signature _____ Date: _____

If a minor, Parent or Guardian Signature _____ Date: _____