SONORAN ORTHOPAEDIC TRAUMA SURGEONS

Patient Demographics

Dr. Gilbert Ortega	Dr. Brian Miller	Dr. Laura Prokuski	Dr. Heather Cole
Dr. Kurtis Staples	Dr. Michael Billhymer	Dr. Thomas Fishler	Dr. David Swanson

Today's Date: | Primary Physician:

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 Spouse's Name:	Race of Patient:

How were you referred to Sonoran Orthopaedic Trauma Surgeons?
☐ Internet ☐ Referral from friend/family (Name:)
☐ Referral from another provider (Provider Name:) ☐ Emergency Department
☐ Insurance list of providers ☐ Advertisement ☐ Other:

Preferred Language of Patient
☐ English ☐ Spanish
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? _________________________________

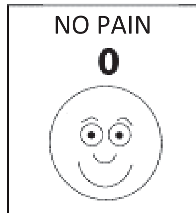
Do you have the following? ☐ Bruising ☐ Joints Giving Way ☐ Hands Feeling Clumsy ☐ Locking/Catching ☐ Weakness ☐ Numbness ☐ Poor Balance ☐ Loss of Control of Bladder ☐ Tingling ☐ Swelling

Current problem is a result of:

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

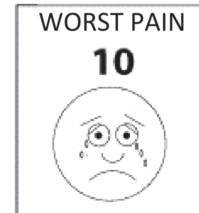
What is your pain level today?

NO PAIN
0



1 2 3 4 5 6 7 8 9

WORST PAIN
10



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?*

Condition		Condition		Condition		Condition	
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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Patient/Guardian signature

Date