

Sonoran Orthopaedic Trauma Surgeons, PLLC

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SONORAN HIP CENTER REGISTRATION FORM

(Please Print)

Primary Care Provider:										Date:		
PATIENT INFORMATION												
Patient's last name:			First:		MI:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.	Marital status:				
						<input type="checkbox"/> Mrs.		Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>				
Is this your legal name?		If not, what is your legal name?			Social Security No:			Birth date:		Age:	Sex:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No										<input type="checkbox"/> M	<input type="checkbox"/> F
Street address:					Home Phone Number:			Cell Phone Number :				
					()			()				
P.O. Box:			City:			State:			ZIP Code:			
Occupation:			Employer:				Employer phone no.:					
							()					
EMAIL ADDRESS:												
INSURANCE INFORMATION												
Policy Name and/or Number:						Insurance Phone No:						
						()						
Subscriber's Name:				Subscriber's Phone Number				Co Payment:				
				()				\$				
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other							
Secondary Insurance (if applicable):			Policy Number:			Contact Phone:			Co Payment:			
						()			\$			
IN CASE OF EMERGENCY												
Name of local friend or relative (not living at same address):					Relationship to patient:		Home phone no.:		Work phone no.:			
							()		()			
							()		()			
<p>SONORAN HIP CENTER IS NOT CONTRACTED WITH PRIVATE HEALTH INSURANCE. WE WILL BILL YOUR INSURANCE AS A COURTESY TO YOU, BUT YOU ARE RESPONSIBLE FOR ANY/ALL FEES RELATED TO YOUR VISITS AND/OR SURGERY. ALL SERVICES REQUIRE PAYMENT ARRANGEMENTS PRIOR TO THE TIME OF SERVICE.</p>												
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance due. I also authorize Sonoran Hip Center and/or my insurance company to release any information required in processing my claim(s).</p>												
Patient/Guardian Signature										Date		

CURRENT MEDICAL HISTORY

Where is Your Pain?

Back L R Pelvis L R Knee L R Other _____
 Hip L R Leg L R Foot L R

When Did Pain Begin? ____ Days ____ Weeks ____ Months ____ Years

Have you had similar pain in the past? _____

When did the pain begin?

No Injury Gradual L Sudden L Other _____
 Injury Please Describe _____ Work Related Date of Injury _____

How severe is your pain? 0 1 2 3 4 5 6 7 8 9 10 (please circle level of pain)

Is the pain Sharp Dull Achy Stabbing Throbbing Burning Is the pain Constant Intermittent (comes and goes) Does the pain wake you from sleep? Yes No

Do you experience any of the following symptoms:

Numbness Weakness Joints giving out Swelling Tingling
 Locking/catching Trouble with Balance

What activities make your pain worse?

Bending Coughing Exercise Squatting Putting on Shoes/Socks
 Walking Sneezing Running Twisting Getting In/Out of Car

Have your symptoms recently changed? Better Same Worse What makes your symptoms better? Rest Ice Heat Medication _____

Have prior test been performed to evaluate this problem? _____

PRIOR MEDICAL HISTORY

Do you currently have (or had prior) any of these conditions?

Cancer Heart Attack Heart Failure Diabetes Blood Clots Stroke Urinary Infection
 High Blood Pressure Kidney Failure Other: _____

Do you have any allergies? _____**PREVIOUS SURGICAL HISTORY**Have You Had Surgery on the Body Part You Are Here For? Yes No Date: _____

Please List All Previous Surgeries:

1. _____ Date: _____ City/State _____
 2. _____ Date: _____ City/State _____
 3. _____ Date: _____ City/State _____
 4. _____ Date: _____ City/State _____

CURRENT MEDICATIONS

Name of Medication:	Dosage:	Frequency:	Start Date:

CURRENT PHARMACY INFORMATION

Name and Phone of Pharmacy: _____

Address and Cross Streets: _____

Phone Number: _____

FAMILY AND SOCIAL HISTORY

Family History:

Diabetes <input type="checkbox"/> Whom: _____	High Blood Pressure <input type="checkbox"/> Whom: _____
Degenerative Arthritis <input type="checkbox"/> Whom: _____	Heart Disease <input type="checkbox"/> Whom: _____
Rheumatoid Arthritis <input type="checkbox"/> Whom: _____	Other: _____ <input type="checkbox"/> Whom: _____
Exercise: Sedentary <input type="checkbox"/> < 3 Times per Week <input type="checkbox"/> > 3 Times per Week <input type="checkbox"/> Daily Vigorous Exercise <input type="checkbox"/>	
Do You Use Tobacco: Never <input type="checkbox"/> Past Smoker <input type="checkbox"/> Yes <input type="checkbox"/> Packs per Day: _____	
Do You Drink Alcohol: Yes <input type="checkbox"/> No <input type="checkbox"/> Qty per week: _____	
Do You Use Street Drugs: Yes <input type="checkbox"/> No <input type="checkbox"/> Type and Frequency: _____	
Do You have: Frequent Falls <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Vision Loss <input type="checkbox"/> Do You Live Alone: Yes <input type="checkbox"/> No <input type="checkbox"/>	

REVIEW OF SYMPTOMS

Please note if you experience any of the following symptoms and in what year?

General			Year	Endocrine/Hematologic			Year
Loss of Appetite	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Easy Bruising/Bleeding	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Recent Weight Loss	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Thyroid Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Respiratory				Heat/Cold Intolerance	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Shortness of Breath	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Cardiovascular			
Cough	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Chest Pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Kidney/Bladder/Urine				Chest Palpitations	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Painful Urination	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Eyes			
Blood in Urine	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Blurry Vision	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Gastrointestinal				Double Vision	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Nausea/Vomiting	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Loss of Vision	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Blood in Stool	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Skin			
Heartburn	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Frequent Rashes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Neurological				Skin Ulcers or bumps	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Ears/Nose/Throat			
Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Trouble Swallowing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Dizziness	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Hearing Loss	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

REFERRAL INFORMATION

Please let us know who we should thank, if you were referred:

By a Doctor's Office or Therapist:

By an Individual or Other:

CONTACT INFORMATION

Name of individual designate to receive information regarding you:

Contact Information for Designated Contact: Phone () Phone ()

Release of Information for this Contact Yes No

Primary Language: English Spanish Japanese French Other: _____

Race: American Indian/Alaska Native Asian Black/African America Hawaiian/Pacific White

Ethnicity: Hispanic or Latino Not Hispanic or Latino

I ACKNOWLEDGE I HAVE RECEIVED AND READ THE NOTICE OF PRIVACY PRACTICES (HIPPA) FROM SONORAN HIP CENTER.

Patient Signature: _____ Date: _____

