Sonoran HIP CENTER

Subsidiary of Sonoran Orthopaedic Trauma Surgeons PLLC

Patient Demographics

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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	Race of Patient:

How were you referred to Sonoran Hip Center? ☐ Internet ☐ Referral from friend/family (friend/family name:) ☐ Referral from another provider (provider name:) ☐ Emergency Dept. ☐ 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 no.:	Policy no.:	Co-payment:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

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 Hip Center 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

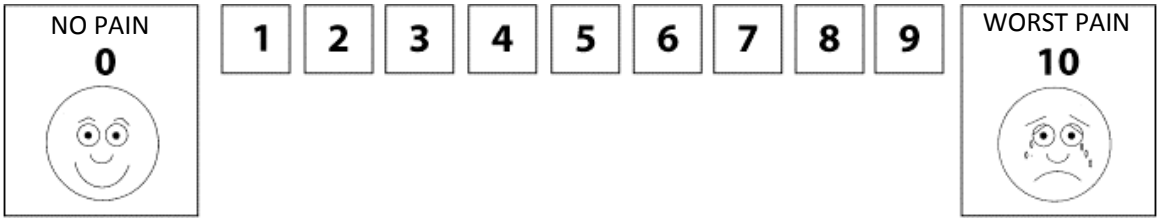
Which ER? _____

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: *(check all that apply)*:

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

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	Intestestinal/Bowel Problems	☐ Yes ☐ No	Psychological problems	☐ Yes ☐ No		

FINANCIALLY RESPONSIBLE PERSON (IF DIFFERENT FROM ABOVE)			
Responsible party name:	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. no.:	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 _____