

Patient Information

Section A-Your Information

Name-First: _____		Last: _____		MI: _____	SS# _____
Mailing Address: _____			City & State: _____		Zip Code: _____
Gender: _____	Marital Status: _____		Birthdate: _____		Age: _____
M F	M S W D				
Home Phone: _____		Work Phone: _____		ext: _____	Other Phone: _____
Are you currently _____ employed _____ unemployed _____ retired _____ disabled _____ a student _____					
Current Employer (if applicable) _____				Phone: _____	
Parent/Guardian (if patient is under 18) _____				Phone: _____	
Emergency Contact Name: _____			Relationship: _____		Phone: _____
Primary Care Doctor: _____			Referring Doctor: _____		

Section B-Your Injury

Date of Injury: _____	
Was this an auto accident? _____ No _____ Yes	
Were you injured at school? _____ No _____ Yes If Yes , name of school attending: _____	
Were you injured at work? _____ No _____ Yes If No , please skip to section C , otherwise complete below:	
Name of Worker's Comp Insurance Company: _____ Phone: _____	
Claim#: _____ Adjuster's Name: _____	

Section C-Your Insurance (if you show us your card(s) to photocopy, you do not need to complete this section)

Primary Health Insurance: _____		ID# _____
Policy Holder: _____		Date of Birth: _____
SS# _____	Policy Holder's Employer: _____ Phone: _____	

Insurance/Medical records Authorization and Assignment

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare or other insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare or other insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare or other insurance company.

I hereby authorized Central Maine Orthopaedics, P.A. to release medical information to physicians and others responsible for my care and to third parties paying for my care. I hereby consent to medical treatment by Central Maine Orthopaedics, P.A.

I understand that even though I may or may not have some type of insurance coverage, I am responsible for payment of services. I understand that any cost, including attorney's fees, incurred in the collection of this account will become my responsibility.

Signature: _____ Date: _____

CMO Health Information

To be completed by Patient:

Pt Acct.# _____

Patient Name: _____ Date of Birth: _____ Today's date: _____

Reason for today's visit? _____

Were you injured at work? Y N Are you hearing impaired? Y N Do you need an interpreter? Y N

Current Medications (including dosages):

_____	_____
_____	_____
_____	_____
_____	_____

Do you have any allergies? Y N Please list: _____

Previous Surgeries (please list with their approximate date):

Hospitalizations (please list all of your hospitalizations in the past 5 years with the purpose and date):

Past Medical History: Please check any conditions you have or have had in the past:

Are you diabetic? Y N Do you take insulin? Y N Dose? _____

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke/CVA |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Coma |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis/Painful Joints | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Anemia | <input type="checkbox"/> Poor Circulation/Bruising | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver disease/Hepatitis | |

Comments: _____

Height: _____ Weight: _____ Date of last Dexascan (Osteoporosis): _____

Other Physicians involved in your care: _____

Primary Care Physician: _____

Specialists: _____

CMO Health Information (cont.)

Family History: Have your relatives had any of the following medical conditions? Please place a check under the appropriate columns:

	Unknown	Healthy	Arthritis	Cancer	Diabetes	Heart Trouble	High Blood Pressure	Lung Disease	Stroke
Mother									
Father									
Brother(s)									
Sister(s)									
Children									
Aunts/Uncles									
Grandparents									

Review of Systems: Please check any current conditions:

HEENT:

- Blurred or double vision
- Temporary loss of vision
- Sinus infections
- Mouth sores
- Bleeding gums
- Nose bleeds
- Ringing in the ears

Neuro/Psych:

- Frequent headaches
- Seizures
- Tremors
- Anxiety
- Depression
- Fatigue
- Memory loss
- Numbness in arms/legs
- Weakness in arms/legs

Respiratory:

- Productive cough
- Coughing up blood
- Shortness of breath
- Wheezing

Cardiovascular:

- Chest pain
- Irregular heart rate
- Rapid heart rate
- Shortness of breath walking up one flight of stairs
- Shortness of breath at night
- Calf pain with walking
- Poor circulation

Gastrointestinal:

- Indigestion
- Nausea/vomiting
- Gastric reflux
- peptic ulcers
- Constipation
- Diarrhea
- Rectal bleeding
- Hemorrhoids

Musculoskeletal:

- Swollen joints
- Frequent fractures
- Extremity swelling
- Easy bruising
- Cold intolerance

Urinary:

- Painful urination
- Frequent urination
- Blood in urine
- Incontinence

Integumentary:

- Rash
- Hives
- Non-healing sore

Gynecological:

- Irregular menstrual periods
- Bleeding between periods
- Abnormal pap smear
- Breast lump

General:

- Excessive thirst/urination
- Weight change
- Fevers
- Enlarged glands/lymph node

Social History:

Occupation: _____

Tobacco Use Y N Packs per day _____ How many years? _____ Chew? Y N Snuff? Y N

Alcohol intake? Y N Approximate number of drinks/day: _____

Recreational drug use? Y N Describe: _____

Domestic status: Single Married Partner Lives Alone