MILLER ORTHOPEDIC SPECIALISTS

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Patient Name _____ Marital Status: M S D W
Last First MI Maiden (Circle One)

Social Security #: _____ Date of Birth: _____ Age: _____ Sex: M F

Address: _____
Street City State Zip

E-mail Address: _____ Race:_____ Ethnicity:_____ Preferred Language:_____

Phone Home: (_____)_____#____ Work: (_____)_____#____ Cell: (_____)_____#____

NOTE: Please designate the phone number that is best to reach you for reminder/reschedule/call back (ex: #1-best number, #2-next best number etc.)

IF WE ARE UNABLE TO REACH YOU, WHO MAY WE RELEASE MEDICAL AND/OR BILLING INFORMATION TO? (Emergency Notification and Contacts)

(Exception: X-Ray, Path and/or Lab results will be given only to the patient or "designee". Results will not be left on an answering machine.)

_____
Name Relationship Phone #

_____
Name Relationship Phone #

Referring Doctor: _____ Family Doctor: _____
Name City State Name City State

Reason for exam:_____

How did incident occur? _____

Body Part: _____ ❑ Left ❑ Right ❑ Both

Date of Injury? _____ ❑ Gradual Onset

Have you been treated for the injury prior to your appointment today? ❑ Yes ❑ No

If yes, date you were first treated? _____ Where? _____ Who treated you? _____

Were **X-Rays** **Bone Scan** **CT Scan** **MRI** **EMG/NCV** taken? *(Circle all that apply)*

Location these were taken: _____

Employment Information

Company Name:_____
Address: _____
City State Zip

Occupation: _____

If this is an injury, is the injury related to an on the job accident? ❑ Yes ❑ No

If Yes:

a) Have you reported the accident to your employer? ❑ Yes ❑ No
b) Were you referred by a Work Comp Doctor? ❑ Yes ❑ No

If No:

a) Was this injury a result of a car accident? ❑ Yes ❑ No
b) Did the injury occur on another person's property? ❑ Yes ❑ No

Do you have an attorney representing you in a claim regarding the above injury?

*Attorney:*_____
Name Address City State Zip

INSURANCE INFORMATION (copy of insurance card is needed)

Insurance Name: _____ Policy Holder: _____ _____-_____-_____
Primary Name Date of Birth SS# of Policy Holder

Insurance Name: _____ Policy Holder: _____ _____-_____-_____
Secondary Name Date of Birth SS# of Policy Holder

If patient is a minor, please print name of parent or guardian responsible for bill: (*must be present)*

Guardian Name:_____

Address: _____
Street City State Zip

Date of Birth_____ Soc Sec # _____-_____-_____
MM/DD/YY

Revised 10/17/18

Patient Name: _____ Age: _____ Date:_____

Please list ***ALL MEDICATIONS*** Prescription/Non-Prescription, including Herb/Dietary Supplements that you are presently taking: (f you should need more space, please turn page over.)

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Please list ***ALL ALLERGIES*** drug, food or other; including ***LATEX*** if applicable:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Please list ***ALL PAST SURGERIES AND DATES:***

_____ _____
_____ _____
_____ _____

***My pharmacy preference is*:** _____
Name Addresss City State

Have you had, or do you presently suffer from:

Yes/No			***Yes/No***		
❑	❑	Cancer	❑	❑	HIV
❑	❑	Seizures/Stroke	❑	❑	Chemical Dependency/Alcoholism
❑	❑	Liver/Hepatitis/Jaundice	❑	❑	Reaction to General / Local Anesthesia
❑	❑	Heart Failure/Heart Attack	❑	❑	Have you ever had cortisone?
❑	❑	Diabetes	❑	❑	Do you smoke? How much? _____
❑	❑	Emphysema/Chronic BronchitisAsthma	❑	❑	Are you pregnant?
❑	❑	Thyroid Disorder	❑	❑	Have you gone through menopause?
❑	❑	Blood Clots/Phlebitis	❑	❑	Have you had a bone density test in the last 2 years?
❑	❑	Urinary Tract/Kidney/Bladder Infection	❑	❑	Have you ever taken Coumadin?
❑	❑	Sleep Apnea			

List any other medical problems not mentioned above: _____

_____

Significant family/health history: _____

_____

I hereby verify the above information is accurate and complete to the best of my knowledge:

Signature: _____ Date:_____

Reviewed by: _____ Date:_____

_____ Date:_____

REFERRAL SOURCE: How did you hear about Miller Orthopaedic Affiliates: (Please Check ONE)

❑ Newspaper Ad _____ ❑ Radio Ad _____ ❑ Yellow Pages ❑ Website ❑ Presentation
❑ Family Doctor ❑ Family Member ❑ Friend ❑ ER Jennie Ed ❑ ER Mercy ❑ ER Other _____
❑ Physical Therapist _____ ❑ Coach _____ ❑ Athletic Trainer _____
❑ Previous Patient ❑ MOA Employee _____ ❑ Other _____