Methodist ORTHOPAEDIC SURGICAL ASSOCIATES | Methodist MEDICAL GROUP

Patient Information

Patient Name: _____ _____
First MI Last Preferred Name

SS#:_____ Birth Date:_____ Age:_____ Height:_____ Weight:_____ Sex: Male ☐ Female ☐

Address:_____
Street Address Apt. # City State Zip

Patient lives in: ☐ Home ☐ Apartment ☐ Nursing Home ☐ Name of Nursing Home Ph: _____

Cell #:_____ Work #:_____ Home #: _____

Email Address: _____ Driver's License #: _____

Patient's Employer:_____ Address, City, Zip: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____

Work Status: ☐ Working Full-time ☐ Working Part-time ☐ Retired ☐ Student ☐ Disabled ☐ On Leave Occupation:_____ Employer: _____

Guardian Information (If patient is a Minor/under the age of 18)

Name:_____ Relationship to Patient: _____

SS#:_____ Birth Date:____/_____/_____ Age:_____ Height:_____ Weight:_____ Sex: Male ☐ Female ☐

Address:_____
Street Address Apt. # City State Zip

Primary Care Physician:_____ Phone: _____

Section I. Primary Insurance (If you do not have insurance, please skip to Section II.)

Policyholder's Employer:_____ Policyholder's Name: _____

Policy #:_____ Group#:_____ Policyholder's Date of Birth:_____

Patient's relationship to Policyholder: ☐ Self ☐ Spouse ☐ Legal Guardian ☐ Dependent ☐ Other: _____

Secondary Insurance

Policyholder's Employer:_____ Policyholder's Name: _____

Policy #:_____ Group#:_____ Policyholder's Date of Birth:_____

Patient's relationship to Policyholder: ☐ Self ☐ Spouse ☐ Legal Guardian ☐ Dependent ☐ Other: _____

Methodist ORTHOPAEDIC SURGICAL ASSOCIATES

Name:_____ Date:_____ DOB:_____

Date of Injury:_____ Referred by: _____

Family Physician:_____ Phone: _____

Details of Injury: (How? Where? Any Treatment?) _____

_____

Body part being seen for: _____

Side of body: (check) ☐ Right ☐ Left ☐ Both Dominant Hand (check): ☐ Left ☐ Right

Date symptoms began:____/____/_____ Current Symptoms: _____

If there is pain, where is it located?_____ Pain Level (1-10; 10 being worst): _____

Medical History (High Blood Pressure, Diabetes, Emphysema, Gastric Reflux, etc.) _____

_____

_____

Patient Medications:_____

_____

_____ ☐ See Attached List

Pharmacy:_____ Address:_____

HOSPITALIZATIONS/SURGERIES	YEAR	SURGEON/HOSPITAL

Patient Drug Allergies: _____

☐ No Known Allergies

FAMILY HISTORY						
Member	Alive/Deceased				Age	Heath Status
Grandmother(mom's)		A		D		
Grandfather (mom's)		A		D		
Grandmother (dad's)		A		D		
Grandfather(dad's)		A		D		
Father		A		D		

FAMILY HISTORY						
Member	Alive/Deceased				Age	Heath Status
Mother		A		D		
Sister/Brother		A		D		
Sister/Brother		A		D		
Sister/Brother		A		D		
Sister/Brother		A		D		

Review of systems (please check if you are currently or have had problems with these and describe)

❒ Fevers ❒ Chills ❒ Night Sweats ❒ Lethargy ❒ Weight gain or loss of 10 pounds in the last 12 months ❒ Depression
❒ Anxiety ❒ Hallucinations ❒ Eye pain ❒ Change in Vision ❒ Earache ❒ Ear drainage ❒ Nasal drainage ❒ Throat Pain
❒ Change in voice ❒ Chest Pain ❒ Irregular Heart beat ❒ Stroke ❒ Shortness of breath while lying flat
❒ Shortness of breath ❒ Wheezing ❒ Oxygen usage at home ❒ Abdominal pain ❒ Nausea ❒ Jaundice ❒ Ulcers
❒ Constipation ❒ Diarrhea ❒ Vomiting ❒ Painful Urination ❒ Blood in urine ❒ Flank pain ❒ Urinary incontinence
❒ Numbness in genital area ❒ Neuropathy ❒ Seizures ❒ Focal weakness ❒ Focal numbness ❒ Sciatica
❒ Balance problems ❒ Diabetes ❒ Excessive thirst ❒ Cold intolerance ❒ Heat intolerance ❒ Cancer ❒ Tuberculosis
❒ Blood clot ❒ Arthritis ❒ Hepatitis ❒ High Blood Pressure ❒ Skin issues: _____ ❒ Hay fever/Allergies
Other:_____

Social History

Do you drink alcohol? ☐ No alcohol consumption ☐ Yes, consumes alcohol ☐ Social Drinker ☐ Previous Alcoholism
Do you use tobacco? ☐ Never ☐ Currently (everyday) ☐ Currently (some days) ☐ Formerly
Do you overuse/abuse? ☐ Never ☐ Currently ☐ In the past
Exercise regularly? ☐ Yes ☐ No Times per week and type:_____
Do you use an assistive device for ambulation (cane, walker, etc.)? ☐ Yes ☐ No Type:_____
Patient/Legal Guardian Signature: _____ Relationship to Patient:_____ Date:_____

Methodist ORTHOPAEDIC SURGICAL ASSOCIATES

We are required by law to ask and update your medical record. Please complete the information below.
(PLEASE PRINT ALL INFORMATION)

Primary Language (Check One)

☐ English ☐ Spanish ☐ Other:_____

☐ Decline to Answer

Ethnicity (Check One)

☐ Not Hispanic or Latino ☐ Hispanic or Latino

☐ Decline to Answer

Race (Check One)

☐ White ☐ Black / African American ☐ Asian ☐ Hispanic / Latino ☐ American Indian or Alaskan Native

☐ Native Hawaiian or other Pacific Islander ☐ Other: _____ ☐ Decline to Answer

Religion (Check One)

☐ Baptist ☐ Catholic ☐ Christian ☐ Non -Denominational ☐ Other:

_____

☐ Decline to Answer

How Did You Hear About Us?

☐ Online Appointment Request
☐ Physician Referral
☐ Urgent - Acute Care
☐ Hospital ER
☐ Internal Referral
☐ Internet Search
☐ Social Media
☐ High School Affiliation
☐ Professional - College Sports Affiliation
☐ Magazine - Newspaper - Print Ad
☐ Insurance Carrier Referral
☐ Workers Compensation
☐ Friends - Family - Word of Mouth
☐ Other: _____

Was there an injury? ☐ Yes ☐ No Work Related? ☐ Yes ☐ No Car Accident? ☐ Yes ☐ No

Sports Related? ☐ Yes ☐ No

Attorney Involved? ☐ Yes ☐ No

I understand and agree that I am responsible for all services rendered in the event this is work related and my claim is denied when filed to worker's compensation. I understand that Methodist Medical Group/Methodist Orthopaedic Surgical Associates (MOSA) does not file any third-party insurance for motor vehicle or other accidents.

By signing below, I am verifying that the information provided is complete and accurate.

_____ _____

Signature of Patient / Legal Guardian Relationship to Patient

_____ _____

Printed Name Date