PATIENT NAME:

Patient's Address: **Home Phone:**_____ **Mobile Phone:**_____			**PCP Name, Address & Phone:**
Date of Birth:	**Age:**	**Sex:** ☐ **M** ☐ **F**	**Referred By:**
Marital Status:	**Height/Weight:**		**Emergency Contact** (name, phone & relationship)**:**

IF PATIENT IS A MINOR: Mother's Name & Phone: _____ Mother's DOB: _____

Father's Name & Phone: _____ Father's DOB: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline **Preferred Language**:

Race: ☐ White ☐ African American ☐ American Indian ☐ Asian ☐ Hispanic ☐ Decline ☐ Other_____

ARE YOU A STUDENT? Y N ☐ Full-Time ☐ Part-Time **ARE YOU EMPLOYED? Y N** ☐ Full-Time ☐ Part-Time ☐ Retired

EMPLOYER NAME, ADDRESS, PHONE: **OCCUPATION:**

WHY ARE YOU SEEING THE DOCTOR TODAY? Specify affected body parts and whether it's on the right, left or both sides. List symptoms.

SEVERITY OF PAIN: (NONE) 0 1 2 3 4 5 6 7 8 9 10 (WORST IMAGINABLE)

DATE PROBLEM STARTED: **WHAT BROUGHT ON THE PROBLEM?**

Is today's condition a result of an accident? Y N ☐ Auto Accident ☐ Work Accident ☐ Other: _____

Insurance Adjustor Name: _____ **Phone:**_____ **Fax:** _____

Claim #: _____ **If work related, Supervisor's Name**:_____ **Fax:** _____

Have you had any previous treatment for this condition prior to today's appointment? Describe previous care below.

Respond Y or N	**Facility or Doctor**	**Date:**	**Type of Treatment or Test**
ER Dept/Urgent Care Y N			
X-rays, MRI, CT Y N			
Other tests Y N			

ALLERGIES: Are you allergic to any medications, latex, rubber, x-ray contrast, metals or other substances? **Y N**

If yes, please list allergy and type of reaction.

SURGERIES – List all surgeries with approximate dates or check NONE.

☐ **NONE**

PATIENT NAME:

MEDICATIONS – List prescriptions, over the counter medications and herbal remedies with strength and dose, or attach a list.
☐ **NONE**

RETAIL PHARMACY (name & address)**:** _____

MAIL ORDER PHARMACY: _____

SOCIAL HISTORY:
Do you use any assistive devices? Y N (check all that apply) ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Walker ☐ Other: _____
Do you live alone? Y N Live with: ☐ Spouse ☐ Parents ☐ Children ☐ Other_____
Do you drink alcoholic beverages? Y N Kind and frequency:
Smoking Status: ☐ Current Daily ☐ Current Occasionally ☐ Heavy 10+daily ☐ Light 10-daily ☐ Former ☐ Never
Smokeless Tobacco Status: ☐ Never ☐ Quit ☐ Current _____ x per day
Do you have steps in your home? Y N **Hand Dominance**: ☐ Right-Handed ☐ Left Handed ☐ Ambidextrous

MEDICAL HISTORY (please check all that apply to you) ☐ NONE		
☐ AIDS/HIV	☐ High Blood Pressure	☐ Other (please list all medical problems):
☐ Anemia	☐ History of MRSA	
☐ Asthma	☐ Kidney Disease	
☐ Bladder Problems	☐ Liver Disease	
☐ Bleeding Problems	☐ Lung Disease	
☐ Cancer (describe)	☐ Problems with anesthesia	
☐ Depression	☐ Prostate	
☐ Diabetes	☐ Psychiatric Problems	
☐ Fibromyalgia	☐ Seizures	
☐ Gout	☐ Stomach Problems	
☐ Heart Disease	☐ Stroke	
☐ Hepatitis	☐ Ulcer Disease	

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES** The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. Which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician. _____ (initials)

2. **ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION**
I hereby authorize and direct my insurance carrier (s) to issue payment check (s) directly to PITTSBURGH BONE, JOINT & SPINE, INC. for medical services rendered to myself and/or dependants. I understand that I am responsible for deductibles, copayments and any amount not covered by my insurance. _____ (initials)

3. **MEDICARE / MEDICAID ID#**_____
Patient's certification authorization to release information and payment request. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treating me. _____ (initials)

DATE: _____ PATIENT'S or REPRESENTATIVE's SIGNATURE _____