GULF COAST ORTHOPEDICS

A Division of Houma Orthopedic Clinic, AMC

Thank you for choosing Gulf Coast Orthopedics. We are committed to providing you with quality and comprehensive orthopedic care. Please help us by completely filling out all of the information below. We will keep this information confidential and only release it only with your consent. If you need assistance filling out this form please notify the receptionist.

Demographics

Please print all information.

Patient's Name: | Today's Date:

Race: (Please circle) Hispanic | American Indian | Asian | Black/African American | White | Other:

Ethnicity: (Please circle) Hispanic or Latino | Not Hispanic or Latino | Unknown by patient

Sex: (circle one) Male Female | Date of Birth: | Language: English / Spanish | Age:

Address: | Mailing Address:

City: | State: | Zip Code:

Social Security Number:

Home Telephone: | Work Telephone: | Cell Telephone:

If a minor, name of guardian and relationship: | email Address:

Notify in Case of Emergency

Name: | Relationship:

Home Telephone: | Work Telephone: | Cell Telephone:

Billing Information

Who is Responsible for the bill?

Workers Compensation ❑ Company Name: ______________________

Primary Insurance Company ❑ Insurance Company: ______________________

Insurance Address, City, State, Zip: ______________________ Telephone Number: __________

Name of Insured: ______________________ Insured Date of Birth: __________

Contract or Policy Number: ______________________ Group Number: __________

Secondary Insurance Company ❑ Company Name: ______________________

Insurance Address, City, State, Zip: ______________________ Telephone Number: __________

Name of Insured: ______________________ Insured Date of Birth: __________

Contract or Policy Number: ______________________ Group Number: __________

Self Payment ❑

Attorney ❑ Name & Phone Number: ______________________

Employment History

Are you currently employed? Yes ❑ No ❑ Name of Employer: __________ What is your job title: __________

Occupation: ______________________

Signature: ______________________ Date: __________

Patient Name: ______________________________

Social History

Are you: Single ❑ Married ❑ Divorced ❑ Widowed ❑

Living Arrangements: Home alone ❑ Home with Spouse ❑ Assisted Living ❑ Nursing Home ❑

Do you presently smoke tobacco? Yes ❑ No ❑ **If no, have you ever smoked** Yes ❑ No ❑ **When did you quit?**

If yes, please list the amount you smoke ________ pack / day ________ packs / week ________ Number of years smoked

Do you drink alcohol regularly? Yes ❑ No ❑

If yes, please list the amount and type ingested per day: ______________________________

Pharmacy/Location ______________________________ **Cardiologist** ______________________________

Home Health ______________________________ **Physical Therapist** ______________________________

Problem

What are you seeing the doctor for today? ______________________________

How long have you had these symptoms: ______________________________

Date of accident or injury: ______________________________

Where did it occur? ______________________________

How did the accident happen? ______________________________

Who, if anyone, has been treating you for this problem? ______________________________

What treatment, if any, have you had? ______________________________

Have you had any x-rays for this problem? ______________________________

When? ______________________________ Where? ______________________________

Have you had a CT Scan, Myelogram or MRI for this problem? ______________________________

When? ______________________________

Where? ______________________________

Nerve Study ______________________________ When? ______________________________

Where? ______________________________

Referring Physician ______________________________

Medications

Drug	Dosage	Drug	Dosage
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Allergies

Do you have a history of latex allergy? Yes ❑ No ❑

Drug	Reaction	Drug	Reaction
1.		6.	
2.		7.	

Patient Name ____________________

Past Medical History

Illness / Injury	Yes	No	Illness / Injury	Yes	No
High blood pressure			Kidney disease		
Diabetes			Liver disease		
Heart attack			Females ONLY: Are you or could you be pregnant?		
Chest pain or angina			AIDs or HIV Infection		
Stroke			Thyroid problems		
Cancer			Shortness of breath		
Hepatitis			Blood Clots		
Stomach Ulcers			Bleeding tendency		
Arthritis			Accidents / Broken bones (please list)		
Gout					
Anesthetic complications					

Past Surgical History

Year	Name of Operation	Type of Anesthetic (general, regional, local)	Complications

Family Medical History (Do you have a family history of any of the following illnesses?)

Illness	Yes	No	Illness	Yes	No
Cancer			Rheumatoid Arthritis		
Heart Disease			Degenerative Arthritis		
High Blood Pressure			Thyroid Disease		
Diabetes			Immune Disorders		

Review of Systems

	Yes	No		Yes	No		Yes	No
Constitutional Symptoms			**Gastrointestinal**			**Neurological**		
Recent weight change			Loss of appetite			Frequent headaches		
Fever			Nausea or vomiting			Light headed or dizzy		
Unexplained sweating			Frequent diarrhea			Seizures		
Eyes			Constipation			Numbness or tingling		
Wear glasses or contacts			Rectal bleeding or blood in stool			Tremors		
Blurred or double vision			Black tarry stools			Paralysis		
Glaucoma			Regular abdominal pain or heartburn			**Psychiatric**		
ENT			**Genitourinary**			Memory loss or confusion		
Hearing loss			Frequent urination			Anxiety		
Regular nose or gum bleeding			Burning or painful urination			Depression		
Sore throat			Blood in urine			Insomnia		
Swollen glands in neck			Incontinence or dribbling			**Endocrine**		
CV			Female:# of pregnancies			Glandular or Hormone Problem		
Irregular heart beats			Female:# of miscarriages			Excessive thirst or urination		
Shortness of breath w/walking or lying flat			**Musculoskeletal**			Heat or cold intolerance		
Swelling in feet, ankles, and hands			Joint pain			Changes in hair or nails		
Fainting spells			Joint stiffness and swelling			**Hematology**		
Elevated cholesterol			Morning stiffness			Bruising tendency		
Respiratory			Difficulty walking			Amnesia		
Chronic or frequent coughing			Muscle cramping			Need for past transfusion		
Spitting up blood			**Integumentary**					
Regular shortness of breath			Rash or itching			Height		
Emphysema			Changes in skin color			Weight		
Regular wheezing			Varicose veins					

I certify that to the best of my knowledge the preceding information is true and accurate.

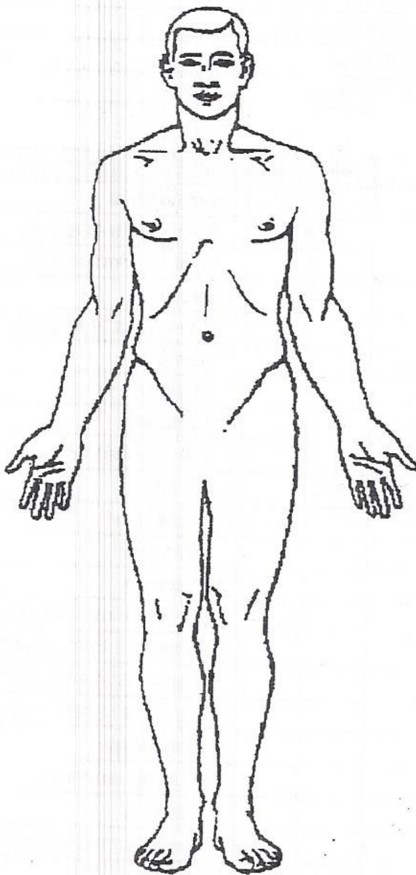
____________________ Patient Signature (or parent if patient is a minor)

____________________ Date

Patient's Name: ____

Using the following symbols, please mark all the appropriate areas of your body that are affected by the corresponding sensations:

ACHING	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
++++++	----------------	ooooooooooooooo	xxxxxxxxxx	////////////////
++++++	----------------	ooooooooooooooo	xxxxxxxxxx	////////////////



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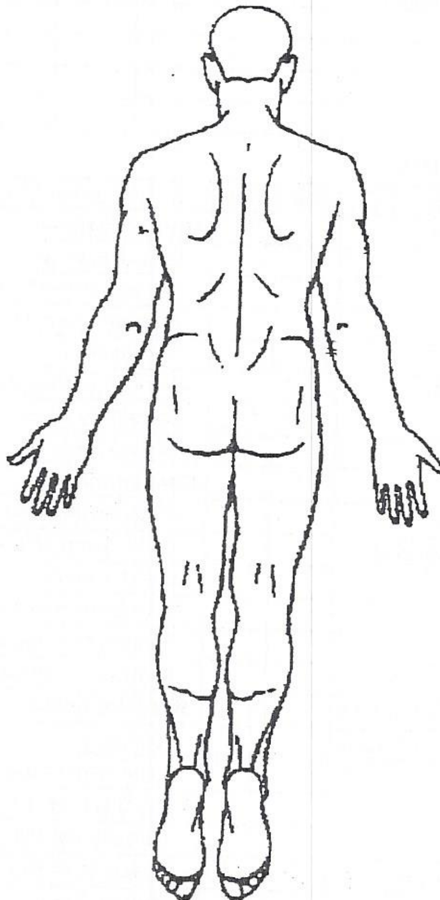

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