SAPERIA ORTHOPAEDICS & SPORTS MEDICINE, INC.
NEW/ ESTABLISHED PATIENT INFORMATION

Welcome to our office. Please complete the following questionnaire. **TODAY'S DATE: / /**

NAME (Last, First, Middle Initial) : **DATE OF BIRTH** : **AGE** : **SEX**

_____ : ___/___/___ : _____ : __M __F

STREET ADDRESS **APT. #** **CITY** **STATE** **ZIP CODE**

HOME TELEPHONE : **CELL PHONE** : **MARITAL STATUS** ☐ **Married** ☐ **Divorced**
( ) : ( ) : ☐ **Single** ☐ **Separated** ☐ **Widowed**

EMAIL ADDRESS:_____

NEAREST RELATIVE (Spouse, Parent, etc.) : **RELATIONSHIP** : **TELEPHONE NO.**

_____ : _____ : **( )** _____

PATIENT'S EMPLOYER (or Parent's if patient is a minor child) : **WORK TELEPHONE NO.** : **OCCUPATION**

_____ : **( )** _____ : _____

EMPLOYMENT STATUS: ☐ **Full Time** ☐ **Part Time** ☐ **Self Employed** : **STUDENT STATUS**

_____ ☐ **Retired** ☐ **Military Duty** ☐ **Not Employed** : ☐ **Full time** ☐ **Part time** ☐ **N/A**

FAMILY PHYSICIAN (Please include name, address & telephone no.) : **WHO REFERRED YOU TO DR. SAPERIA?**

_____ : _____

EXPLAIN IN DETAIL YOUR REASON FOR SEEING THE DOCTOR ☐ RIGHT ☐ LEFT _____

_____

HOW LONG HAVE YOU HAD THIS PROBLEM?_____

WAS THIS THE RESULT OF AN INJURY? ☐ Yes ☐ No ☐ Not Sure DATE OF INJURY_____ /_____/_____

DESCRIBE HOW THE INJURY OCCURRED:_____

WAS IT A WORK RELATED INJURY? ☐ Yes ☐ No **IF OUT OF WORK, GIVE DATES:**_____

DID YOU RECEIVE EMERGENCY MEDICAL TREATMENT? ☐ Yes ☐ No **DATE TREATED:**_____/_____ /____

WHERE?:_____ WERE X-RAYS TAKEN? ☐ Yes ☐ No

HAVE YOU BEEN TREATED BY ANOTHER PHYSICIAN FOR THIS PROBLEM? ☐ Yes ☐ No

NAME OF PHYSICIAN:_____DATE TREATED:_____

DRESSED WEIGHT: HEIGHT: **ARE YOU PREGNANT?** **HOW MANY MONTHS?**

ARE YOU ☐ RIGHT HANDED OR ☐ LEFT HANDED?

Past Medical History (please check all that apply): ☐ None

- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Breast Cancer
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non Insulin Dependent
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity, Morbid
- ☐ Obesity
- ☐ PBPH
- ☐ Prostate Cancer
- ☐ Radiation Therapy
- ☐ Seizures
- ☐ Stroke
- ☐ Other_____

Past Surgical History (please check all that apply): ☐ None

- ☐ Appendix (Appendectomy)
- ☐ Bladder Removed
- ☐ Breast: Mastectomy ○Right ○Left ○Both
- ☐ Breast: Lumpectomy ○Right ○Left ○Both
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Gallbladder Removal

- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Removed: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Hysterectomy: Caesarean
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ Other_____

Past Orthopedic History (please check all that apply): ☐ **None**

- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Bursitis
- ☐ DISH
- ☐ Epidural Injections, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ Other_____

Past Orthopedic Surgery (please check all that apply): ☐ None

- ☐ Ankle Fracture ORIF
  ○Right ○Left ○Both
- ☐ Carpal Tunnel Decompression
  ○Right ○Left ○Both
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ Distal Radius ORIF
  ○Right ○Left ○Both
- ☐ Intermedullary Nailing Femur
  ○Right ○Left ○Both
- ☐ Intermedullary Nailing Tibia
  ○Right ○Left ○Both
- ☐ Joint Replacement: Hip
  ○Right ○Left ○Both
- ☐ Joint Replacement: Knee
  ○Right ○Left ○Both
- ☐ Joint Replacement: Shoulder
  ○Right ○Left ○Both
- ☐ Knee Arthroscopy
  ○Right ○Left ○Both
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Lumbar Spine Surgery: Decompression
- ☐ Lumbar Spine Surgery: Decompression & Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement
- ☐ Rotator Cuff Repair
  ○Right ○Left ○Both
- ☐ Other_____

Medications (please list all current medications or check option which applies)

- ☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)
- ☐ Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

Allergies (please list all known allergies or check option which applies):

- ☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)
- ☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

Patient Information

Preferred Language: _____

Race: _____ Ethnicity: _____

Preferred Pharmacy Name: _____

Preferred Pharmacy Address: _____

Family History (please inform us of your family members' medical history by marking the appropriate box)**:**

	Mother	Father	Sister	Brother	Daughter	Son	Other_____
Hypertension							
Osteoarthritis							
Osteoporosis							
Scoliosis							
Diabetes							
Other_____							

- ☐ **No Family History** (checking this box indicates no past family medical history)

Social History (please check all that apply)

Cigarette Smoking
- ☐ Never Smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily
  - o # packs per day_____

Alcohol Use
- ☐ Do not drink alcohol
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Exercise Frequency
- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never
- ☐ Other_____

INSURANCE BILLING CONSENT

I hereby authorize Saperia Orthopaedics and Sports Medicine, Inc. to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to Saperia Orthopaedics & Sports Medicine, Inc. I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date:_____ Signature:_____