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?**

_______________ : _______________

YOUR REASON FOR SEEING THE DOCTOR ☐ RIGHT ☐ LEFT PART OF BODY_______________

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?

Review of Systems(please check all that apply):

Constitutional	**Eyes**	**Ears, Nose, Throat**
☐ Fevers	☐ Difficulty Seeing	☐ Dentures
☐ Recent weight change	☐ Contact lenses	☐ Problems with hearing
☐ Weakness, fatigue or chills	☐ Temporary loss of vision	☐ Sore throat, hoarseness trouble swallowing
Cardiovascular	**Respiratory**	**Gastrointestinal**
☐ Chest pain	☐ Chronic cough	☐ Constipation
☐ Pacemaker	☐ Pulmonary Embolus	☐ Jaundice
☐ Stent	☐ Sleep apnea	☐ Change in appetite
☐ High or low blood pressure	☐ Wheezing or asthma	☐ Frequent heartburn/indigestion
☐ Problems with circulation		

Genitourinary	Musculoskeletal	Skin
☐ Frequent bladder infections	☐ Past orthopedic infection	☐ Rashes
☐ Frequent nighttime urination	☐ Arthritis	☐ Skin cancers
☐ Incontinence	☐ Fractures (broken bones)	☐ Skin infection
Neurological	**Psychological**	**Endocrine**
☐ Stroke or TIA	☐ Depression	☐ Diabetes type I
☐ Numbness, weakness, tingling	☐ Anxiety	☐ Diabetes type II
☐ Seizures	☐ Other	☐ Thyroid problems
Heme/Lymph	**Breasts**	**Other**
☐ Blood clots	☐ Pain	☐ AIDS
☐ Bleeding/bruising	☐ Discharge	☐ Cancer
☐ Anemia	☐ Other	☐ HIV
☐ Sickle cell		
	PAST SURGICAL HISTORY	
Date	**Operation performed**	**Physician**
	OTHER HOSPITALIZATION	
Date	**Reason**	

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): **ALLERGIC TO LATEX?** __________

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

ALLERGY	Please describe allergic reaction severity & symptoms

Patient Information

Preferred Language: ___________________________ Do you require an interpreter ______________

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
  - # 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

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:**____