

***New Patient Information***

*Blake Ohlson, M.D., Orthopaedics*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: *Male* *Female*

Family MD: \_\_\_\_\_ Date of onset of injury/problem: \_\_\_\_\_

Did a doctor refer you to our office? *YES NO* If yes, list his/her name, address and phone #:

\_\_\_\_\_ Phone: \_\_\_\_\_

Are you working now? *YES NO* What is your occupation? \_\_\_\_\_

Please describe your current orthopaedic problem/ injury: \_\_\_\_\_

Is your problem/injury related to: *(please check)*

\_\_\_\_ Auto-accident \_\_\_\_ Work-related accident \_\_\_\_ Other accident \_\_\_\_ Litigation pending

**MEDICATIONS:** *(Please list all known long-term medications, including current medications, over-the-counter drugs and herbal preparations):*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently taking Coumadin or other blood thinning medications? *YES NO*

**ADVERSE AND ALLERGIC DRUG REACTIONS:** *(please check)*

\_\_\_\_ None \_\_\_\_ Penicillin \_\_\_\_ Sulfa Drugs \_\_\_\_ Other, please list:

Reaction: \_\_\_\_\_

**PAST MEDICAL HISTORY:**

*Have you ever or do you currently have any of the following? Please check all that apply:*

- |                                  |                           |                 |                    |
|----------------------------------|---------------------------|-----------------|--------------------|
| ____ High Blood Pressure         | ____ Cataracts            | ____ Stroke     | ____ Blood Clots   |
| ____ Thyroid Disorder            | ____ Asthma               | ____ MRSA       | ____ Sleep Apnea   |
| ____ Congestive Heart Failure    | ____ Diabetes             | ____ Pneumonia  | ____ Lyme Disease  |
| ____ Fibromyalgia                | ____ Gout                 | ____ Seizure    | ____ Latex Allergy |
| ____ High Cholesterol            | ____ Polio                | ____ Depression | ____ Anxiety       |
| ____ Heart Attack/ Mi Disorder   | ____ GI                   | ____ Kidney     | ____ Stomach Ulcer |
| ____ Hepatitis/Liver Disorder    | ____ Tuberculosis         |                 |                    |
| ____ Seizure Disorder / Epilepsy | ____ Rheumatoid Arthritis |                 |                    |

Please list any other medical problems: \_\_\_\_\_

**PAST MEDICAL HISTORY:**

**Known Significant Operative and Invasive Procedures:** *(type of procedure and dates)*

**Have you ever had a problem with any of the following types of anesthesia?** *(please check)*

\_\_\_ General      \_\_\_ IV Sedation      \_\_\_ Local      \_\_\_ Dental Anesthesia

**If you checked any of the above types of anesthesia, please explain the problem:**

**FAMILY HISTORY:** *(check any family illnesses)*

\_\_\_ Diabetes    \_\_\_ Bleeding problems    \_\_\_ Anesthesia Problems    \_\_\_ Other *(describe below):*

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**SOCIAL HISTORY:**

\_\_\_ Single    \_\_\_ Married    \_\_\_ Widowed      \_\_\_ Live Alone    \_\_\_ Live With Others

Do you smoke tobacco?    YES    NO    How much? \_\_\_\_\_ # of years? \_\_\_\_\_

Do you drink alcohol?    YES    NO    How much? \_\_\_\_\_

History of substance abuse?    YES    NO    If yes, please describe \_\_\_\_\_

Are you or could you be pregnant?    YES    NO

**KNOWN SIGNIFICANT MEDICAL DIAGNOSES AND CONDITIONS:**

Height: \_\_\_\_\_      Weight: \_\_\_\_\_

**Please circle and describe the symptoms that pertain to you:**

YES    NO    Constitutional *(fever, weight loss, etc.):* \_\_\_\_\_

YES    NO    Heart *(chest pain, murmur, irregular beats, etc.):* \_\_\_\_\_

YES    NO    Circulation *(high blood pressure):* \_\_\_\_\_

YES    NO    Respiratory *(asthma, shortness of breath, cough, etc.):* \_\_\_\_\_

YES    NO    Gastrointestinal (GI) *(appetite, diarrhea, constipation, etc.):* \_\_\_\_\_

YES    NO    Urinary *(problems urinating, incontinence, etc.):* \_\_\_\_\_

YES    NO    Musculoskeletal *(arthritis, stiffness, etc.):* \_\_\_\_\_

YES    NO    Skin *(acne, rash, etc.):* \_\_\_\_\_

YES    NO    Neurological *(seizures, weakness, balance, etc.):* \_\_\_\_\_

YES    NO    Psychiatric *(depression, mood liability, other):* \_\_\_\_\_

YES    NO    Endocrine *(thyroid problem):* \_\_\_\_\_

YES    NO    Hematologic *(bleeding tendency, anemia):* \_\_\_\_\_

**OTHER:** Are there other questions or concerns that you have for your Doctor today? If so, please list them below:



**Patient Identification**

Last Name: \_\_\_\_\_  Mr.  Mrs.  Miss SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 First Name: \_\_\_\_\_ Other title \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Middle: \_\_\_\_\_ (Doctor, General, the III, etc...) Sex: Male \_\_\_\_ Female \_\_\_\_  
 Marital Status:  Married  Single  Separated  Divorced  Widowed Relationship to Guarantor: \_\_\_\_\_  
 Student Status:  Full  Part  N/A School: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
 Employment:  Full  Part  None Employer: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
 Address: (This practice will send all correspondence to this address unless you provide us an alternate address below)  
 Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: ( ) \_\_\_\_\_ (RSFH will contact you at this number unless you provide us an alternate number below)  
 May we leave a general voice message for appointment reminders at this contact phone number? Yes \_\_\_\_\_ No \_\_\_\_\_  
 May we leave a general voice message for normal test results at this contact phone number? Yes \_\_\_\_\_ No \_\_\_\_\_  
 In Case of Emergency Contact Name \_\_\_\_\_  
 Relationship \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

**Guarantor/Responsible Party (if different from patient)**

Last Name: \_\_\_\_\_  Mr.  Mrs.  Miss SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 First Name: \_\_\_\_\_ Other title \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Middle: \_\_\_\_\_ (Doctor, General, the III, etc...) Sex: Male \_\_\_\_ Female \_\_\_\_  
 Address: \_\_\_\_\_ Phone: Home ( ) \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: Work ( ) \_\_\_\_\_  
 (Complete only if you want the Practice to communicate with you at an address/phone different than you provided above)  
 Alternate Address: \_\_\_\_\_ Alternate Phone: ( ) \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Primary Insurance**

**Secondary Insurance**

Member/Policyholder (if different from patient)		Member/Policyholder (if different from patient)	
_____	_____	_____	_____
Member/Policyholder ID#	Date of Birth	Member/Policyholder ID#	Date of Birth
_____	_____	_____	_____
Insurance Co. Phone Number	Group #	Insurance Co. Phone Number	Group #
(____) _____	_____	(____) _____	_____
Insurance Co. Address (Street Address/ P.O. Box)		Insurance Co. Address (Street Address/ P.O. Box)	
_____		_____	
City	State	Zip	
_____	_____	_____	_____

**Ongoing Communication Regarding Your Healthcare**

We may release/discuss your health information with following individuals/organizations for the following dates of service, range of time, or event(s): From (MM/DD/YY) \_\_\_\_\_ To (MM/DD/YY) \_\_\_\_\_

Name (Physician, family, etc)	Address	Phone/Fax	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

A separate authorization must be completed if the information being release differs between the individuals/organizations listed above.

**Authorization, Assignment of Benefits, and Referral Medical Release**

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Roper Saint Francis Healthcare for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this form shall be considered as effective and as valid as the original.

I have been provided a copy of the Roper Saint Francis Healthcare Notice of Information Practices.

Signed: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

*Office Use Only:*

**Referred by:** \_\_\_\_\_

## ACCIDENT / INJURY INFORMATION

Are you being seen today as a result of an accident or injury? \_\_\_\_\_

If YES, please provide the following information. If NO, please sign and date at bottom.

Patient Name: \_\_\_\_\_

Insurance Co: \_\_\_\_\_

Subscriber: \_\_\_\_\_

Subscriber ID#: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_

Please describe the injury and how it occurred:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Injury: \_\_\_\_\_ Involved body area: \_\_\_\_\_

Where did injury take place? \_\_\_\_\_

Did injury occur as a result of an accident that was caused by someone else? \_\_\_\_\_

If yes, name and address of person at fault: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Insurance company of person at fault: \_\_\_\_\_

Policy number or claim number: \_\_\_\_\_

Is this injury work-related? \_\_\_\_\_ If yes, has claim been filed for Workers Compensation? \_\_\_\_\_

Name of Workers Compensation Insurance Co. \_\_\_\_\_

**SIGNATURE**

**DATE**

**PHONE NUMBER**