Southwest Orthopaedic Surgery Specialist, PLC
7520 N. Oracle Road, Suite 200 Tucson, AZ 85704
New Patient Paperwork
**** DO NOT leave blanks Fill out form Completely ****

Date: _____/_____/_____ **How did you learn about our office?** _____

Patient's Last Name: _____ First: _____ MI: _____

Sex: ❑ Male ❑ Female Date of Birth: _____/_____/_____ Age: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____Work Phone: (_____) _____

Social Security Number: _____-_____-_____Email Address: _____
(Social required per your insurance)

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Partner ❑ Legal Separated

Spouse/Parent/Guardian Name: _____Relationship: _____

Spouse/Parent/Guardian Phone Number: (_____) _____Email Address: _____

Emergency Contact: _____ Relationship: _____Phone:(_____) _____

Patient's Employer: _____ Occupation: _____

Current work Status: ❑ Regular ❑ Light duty - (how long? _____) ❑ Disabled ❑ Retired
❑ Student ❑ Not working due to this problem

Primary Care Doctor Name: _____Phone: (_____) _____

Pharmacy Preference (include location) _____Phone:(_____) _____

Primary Insurance Information:

Insurance Name: _____ ID Number: _____ Group: _____

Carrier Address: _____ City: _____ State: _____ Zip: _____

Insured: ❑ Self ❑ Spouse ❑ Parent ❑ Other: _____

Policyholder/Subscriber: _____DOB: _____/_____/_____Social Security: _____-_____-_____

Secondary Insurance Information:

Insurance Name: _____ ID Number: _____ Group: _____

Carrier Address: _____ City: _____ State: _____ Zip: _____

Insured: ❑ Self ❑ Spouse ❑ Parent ❑ Other: _____

Policyholder/Subscriber: _____DOB: _____/_____/_____Social Security: _____-_____-_____

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Workers Compensation Information **Is the pain/problem work related? ❑ No ❑ Yes**

Have you filed a Workers Compensation Claim? ❑ No ❑ Yes, Date Filed? _____/_____/_____

Have you missed work due to problem? ❑ No ❑ Yes **Dates:** To: _____From: _____

Carrier Name: _____Date of Injury: _____/_____/_____Claim Number: _____

Adjuster Name: _____Phone: (_____) _____Fax: (_____) _____

Employer Name: _____Phone Number: (_____) _____

Orthopaedic/Medical History

Why are you seeing the doctor today? (Body part) _____ ❑Right ❑ Left ❑ Bilateral (both)

How long has the injury/pain/problem been present? _____Days _____Weeks_____Months_____Years

What started the injury/pain/problem? _____

Has the pain/Problem gotten worse? ❑ No ❑ Yes, How recently? _____

On a scale of 0 - 10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

Quality of pain: ❑ Sharp ❑ Burning ❑ Dull ❑ Aching

Do you have? ❑Swelling ❑Bruises ❑Numbness ❑Tingling ❑ Weakness ❑Giving way ❑ Locking/Catching

What makes the pain worse: ❑ Standing ❑ Walking ❑ Lifting ❑Exercise ❑ Twisting

❑ Lying in bed ❑Bending ❑ Squatting ❑ Kneeling ❑ Stairs ❑ Sitting ❑ Other: _____

(Check all that apply) ❑Continuous ❑Activity related ❑ Night Pain ❑ Unpredictable

What Makes it better: ❑ Rest ❑ Elevation ❑ Ice ❑ Heat ❑ Other: _____

Are you using any assistive devices: ❑ Crutches ❑ Cane ❑ Walker ❑ Wheelchair? ❑ Other: _____?

What treatments have you tried?

❑ Physical Therapy/Exercise How long: _____ ❑ Orthotics ❑ Braces ❑ Steroid Injections

❑ Anti-Inflammatories (name of medication) _____ How long? _____

❑ Narcotic Medication (name of medication) _____ How Long? _____

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Previous Physicians seen for this problem? ❑ No ❑ Yes, if yes give information below.

Physician Name: _____ Phone: (_____) _____

Specialty: _____ Date Seen: _____/_____/_____

Treatments: _____ Reason for Leaving: _____

X-rays and Test for this problem:

❑ X-rays Date: _____/_____/_____ Location: _____

❑ MRI Date: _____/_____/_____ Location: _____

❑ CT Scan Date: _____/_____/_____ Location: _____

❑ Bone Scan Date: _____/_____/_____ Location: _____

❑ Labs Date: _____/_____/_____ Location: _____

❑ Other _____Date: _____/_____/_____ Location: _____

Allergies to Medications (rash, swelling, upset stomach etc.) **❑ No Allergies**

Name of Medication: _____ Reaction: _____Date: _____/_____/_____

Name of Medication: _____ Reaction: _____Date: _____/_____/_____

Name of Medication: _____ Reaction: _____Date: _____/_____/_____

Name of Medication: _____ Reaction: _____Date: _____/_____/_____

Medications (Prescribed and over the counter include when taken) **❑ I take no medications**

Name: _____Dose: _____When taken: _____Medical Reason: _____

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Surgical History: ❑ **No previous surgeries**

Procedure: _____ Date: _____/_____/_____Physician/Hospital Name: _____

Procedure: _____ Date: _____/_____/_____Physician/Hospital Name: _____

Procedure: _____ Date: _____/_____/_____Physician/Hospital Name: _____

Procedure: _____ Date: _____/_____/_____Physician/Hospital Name: _____

MEDICAL HISTORY

Illness: (Currently Being Treated for) Mark the following:

❑ Abnormal Heart Rhythm
❑ Rheumatoid Arthritis
❑ Seizures
❑ Stents
❑ Anorexia/Bulimia
❑ Anxiety
❑ Asthma
❑ Hepatitis_____
❑ Kidney Stones
❑ Bleeding Disorder
❑ Alcoholism
❑ Anemia
❑ Stomach Ulcers
❑ Cancer
❑ Depression
❑ Diabetes
❑ Arthritis
❑ Irritable Bowel
❑ Emphysema
❑ Blood Clots
❑ Bronchitis
❑ Thyroid
❑ Heart Attack
❑ Heart Failure
❑ HIV
❑ Liver Failure
❑ High Blood Pressure
❑ Endometriosis
❑ Gout
❑ Lung Disease
❑ Tuberculosis
❑ Osteoporosis
❑ Ovarian Cyst
❑ KidneyFailure

REVIEW OF SYSTEMS: **Mark if you have any of the following:**

Unexplained weight loss
❑ Change in appetite
❑ Fever, Chills, Sweats
❑ Marked fatigue
❑ Difficulty Sleeping
❑ Bowel/ Bladder Changes

Eye, Ear, Nose, Throat
❑ Difficulty Swallowing
❑ Hoarseness
❑ Nasal Congestion
❑ Hearing/Vision loss
❑ Glasses/Contacts

Cardiovascular
❑ Heart or Chest pain
❑ Abdominal heartbeat
❑ Poor Heart Function
❑ Digestive
❑ Nausea or Vomiting

Respiratory
❑ Morning Cough
❑ Shortness of breath
❑ Productive Cough
❑ Emphysema/COPD

Skin
❑ Frequent Rashes
❑ Frequent Itching
❑ Easy Bruising
❑ Swollen Ankle

Stomach **pain or Ulcers**
❑ Heartburn
❑ Frequent Diarrhea
❑ Frequent Constipation
❑ Blood in Stool

Neurological
❑ Seizures
❑ Blackouts/fainting
❑ Tremors
❑ Headaches/Migraines

Musculoskeletal
❑ Joint Pain/Swelling
❑ Back Pain
❑ Muscle Aches

Genital-Urinary
❑ Burning with Urination
❑ Urinary incontinence
❑ Pelvic pain

Psychiatric
❑ Depression
❑ Stress

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Tobacco:

Currently Smoking? ❑ Yes ❑ No if yes, (# of Packs?) _____per day for _____years

Quit Smoking? ❑ This Year ❑ More than 1 yr ago ❑ More than 5 yrs ago ❑ More than 10 yrs ago

Previously smoked, (#of packs) _____per day for _____years

Alcohol: Drink alcohol? ❑ Daily ❑ 1-2 times per week ❑ 1-2 times per month ❑ 1-2 times per year ❑ Socially

Caffeine Consumption: ❑ Daily ❑ 1-2 times per week ❑ 1-2 times per month ❑ 1-2 times per year ❑ Socially

FAMILY MEDICAL HISTORY **Illness:** (Family history any of the following illnesses?)

Enter initials next to illness that applies:

(M) Mother (**F)**Father (**PGF)**Paternal Grandfather (**PGM)** Paternal Grandmother (**MGM)** Maternal Grandmother (**MGF)** Maternal Grandfather

❑ Cancer _____ ❑ Heart Disease_____ ❑ High Blood Pressure _____

❑ Diabetes_____ ❑ Blood Clots_____ ❑ Rheumatoid Arthritis_____

❑ Degenerative Arthritis _____ ❑ Thyroid Disease_____ ❑Immune Disorder _____

❑Other _____

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FOR THE RELEASE OF MEDICAL INFORMATION:

I authorize Southwest Orthopaedic Surgery Specialist to release any medical information requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my medical care.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:
I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

ASSIGNMENT OF INSURANCE BENEFITS:
I authorize payment of benefits to be paid directly to Southwest Orthopaedic Surgery Specialist. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney fees.

ASSIGNMENT OF MEDIGAP BENEFITS:
I authorize payments of benefits from my MEDIGAP carrier directly to Southwest Orthopaedic Surgery Specialists. This assignment of benefits is considered in force from the date of signing until revoked in writing.

MISSED APPOINTMENT:
When a patient fails to keep an appointment, we have the right to charge a fee for the missed appointment. To avoid missed appointment fees, the patient must notify Southwest Orthopaedic Surgery Specialist 24 hours in advance of the scheduled appointment time. The Price for missed office visit appointment is $35.00. The Price for missed MRI appointment is $100.00. INSURANCE COMPANIES DO NOT PAY FOR MISSED APPOINTMENT CHARGES. We are aware that emergencies do arise.

AUTHORIZED SIGNATURE:
I authorize that I have read this document and completed the requested information to the best of my ability.

_____ _____
Patient Name (Print Full Name) Date Patient Signature

Sign and date below for a patient that is a minor:

_____ _____
Parent/Guardian Name (Print Full Name) Date Signature of Parent or legal Guardian