PATIENT INFORMATION

Please print clearly and complete all blanks

DATE:______________________ REFERRED BY:____ SEX:________________

NAME:____ BIRTHDATE:_______________________
LAST FIRST MIDDLE

MAILING ADDRESS:____
CITY STATE ZIP

TELEPHONE:_______________________ CELL PHONE:______________________ WORK NUMBER:____________________

SS #________________________ MARITAL STATUS:__________ EMAIL:____

EMPLOYER:______________________________________ OCCUPATION:____

EMPLOYER'S ADDRESS:____

****

RACE (circle one): AMERICAN INDIAN – ALASKAN – ASIAN – BLACK – WHITE – HISPANIC

SMOKER STATUS (circle one): EVERY DAY – SOME DAYS – FORMER – NEVER

RELIGION:____

****

NEXT OF KIN:____ BIRTHDATE:_____________________

ADDRESS IF DIFFERENT:____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:____________________ MALE________ FEMALE_____________ TELEPHONE:_______________________

****

EMERGENCY CONTACT:____

ADDRESS IF DIFFERENT:____
ADDRESS CITY STATE ZIP CODE

RELATIONSHIP:____________________ MALE________ FEMALE_____________ TELEPHONE:_______________________

****

RESPONSIBLE PARTY FOR BILLING (if other than patient):

NAME:____ RELATIONSHIP TO PATIENT:_______________________

ADDRESS:____
ADDRESS CITY STATE ZIP CODE

SS #:________________________ BIRTHDATE_______________________________ TELEPHONE:_______________________

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PRIMARY INSURANCE:____________________________ ID#:________________________ GROUP#____________________

NAME OF INSURED:____ INSURED'S BIRTHDATE:____________________

SECONDARY INSURANCE:_________________________ ID#________________________ GROUP#_____________________

NAME OF INSURED:____ INSURED'S BIRTHDATE:____________________

All professional services rendered are charged to the patient's account. Necessary forms will be completed to expedite insurance claims for those plans which the physician files. The patient is responsible for all fees, regardless of insurance coverage.

I hereby assign to the physician all payments for medical services rendered and authorize the physician to release any medical information necessary to process claims and request payments from insurance companies or Medicaid payers. A photocopy of this assignment and authorization shall be considered as valid as the original.

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SIGNATURE:____ DATE:___________________________________

TMG Orthopedic Patient Information

Patient Name____

Date of Birth_____________________________ Reason for visit today ____

What is your pain today (0-10, 10 being the worst) ______________ How long has your pain been there _______________

Have you had a Bone Density Test __________________ Who is your Primary Care Physician _________________________

Medications

____

____

____

____

Allergies

____

____

Past Medical History

	Yes	No		Yes	No
Diabetes	☐	☐	Stroke	☐	☐
Hypertension	☐	☐	Seizure	☐	☐
High Cholesterol	☐	☐	Bleeding disorder	☐	☐
Asthma/Bronchitis	☐	☐	Hepatitis	☐	☐
Emphysema/COPD	☐	☐	HIV/AIDS	☐	☐
Kidney Disease	☐	☐	Back problems	☐	☐
Thyroid Disease	☐	☐	Osteoarthritis	☐	☐
Cancer- type___________	☐	☐	Rheumatoid Arthritis	☐	☐
Fibromyalgia	☐	☐	Depression	☐	☐
Anxiety	☐	☐	Other________________________		

Family History

	Yes	No
Cancer	☐	☐
Diabetes	☐	☐
CHF	☐	☐
Blood Clots	☐	☐
Heart Disease	☐	☐
Hypertension	☐	☐
Bleeding Disorders	☐	☐

Surgical History (Please list all surgeries)

____

____

____

Social History

Occupation____

Last Flu shot____ Last Pneumonia shot____

Use of tobacco ☐Never ☐Previously, but quit_______ ☐Current _____packs/day

Use of alcohol ☐Never ☐Daily ☐Weekly ☐Occasionally

Use of illegal drugs ☐Never Type/frequency____