Southwest Orthopaedic & Reconstructive Specialists

8100 S. Walker #A. Oklahoma City, OK 73139
405.632-4468 Fax 405.632-0436

Date__________

Referred by: Name_________________________________Address_____________________________________
(Circle One) Doctor Hospital Relative Friend Attorney Coach Advertisement

PATIENT INFORMATION: (*Please Print)* Male________Female__________
Legal Name:____Date of Birth:___________Age:______________

Hm Phone_________________Cell Phone________________Social Security No.__________________________

Address____City____________________St____Zip__________

Employer____Employer Phone____________________________
If self, Name and type of business
Student____Full Time Student_____ Part Time Student______
Name of School Location

PERSON TO NOTIFY IN THE EVENT OF AN EMERGENCY:
Name____Relationship to Patient________________________

Address____ Home Phone________________________
Work Phone ________________________

INSURANCE INFORMATION:
Primary: Insured Name ______________________________ Social Security No.__________________

Relationship to Patient ______________________________ Date of Birth ___________________

Policy or ID No. ______________________________ Group No. ___________________

Group or Employer Name ______________________________

Secondary: Insured Name______________________________ Social Security No. ___________________

Relationship to Patient ______________________________ Date of Birth ___________________

Policy or ID No. ______________________________ Group No. ___________________

Group or Employer Name ______________________________

PLEASE GIVE INSURANCE CARD(S) TO RECEPTIONIST FOR COPYING.
Authorization: **My signature indicates that I have read the above and grant authorization of treatment and am responsible for payment of fees.**
I also authorize the release of any medical information requested by my insurance carrier and authorize payment of medical benefits to the physician and Southwest Orthopaedic & Reconstructive Specialists.

Photostat of the above is as valid as the original. ____
Patient, Parent or Legal Guardian's Signature

SOUTHWEST ORTHOPAEDIC AND RECONSTRUCTIVE SPECIALISTS

By whom were you referred? ______________________________

Where/What are your current problems? ______________________________
____

Were you injured? YES NO If so, where and how? ______________________________
____

Date your symptoms/problems begin? ______________________________

Date: ______________________________ Severity on a scale of 1-10: ______________

WORK RELATED ACCIDENT? YES NO AUTO ACCIDENT? □YES □NO

OTHER: ______________________________

Were you treated at another hospital or by another physician?

Name and Date: ______________________________

Have you had x-rays, an MRI, CT scan, ultrasound or other (circle)? Where/when?
____

Did you have surgery performed? □**YES** □**NO**

Date and Type: ______________________________

Are you represented by an attorney? □ **YES** □ **NO**

MEDICATIONS AND DOSAGES (INCLUDE OVER-THE-COUNTER MEDICINES AND INHALERS)

Medication + mg	Dose/how taken	Medication + mg	Dose/how taken

ALLERGIES (MEDICATION AND ORTHERS, INCLUDE TYPE OF REACTION): (circle)

adhesive tape ______________ aspirin ______________ antibiotics ______________
codeine ______________ foods ______________ horse serum ______________
IVP dye ______________ latex ______________ morphine ______________
Penicillin ______________ pollen ______________ sulfa ______________
tetanus ______________
others: ______________________________
____

SURGERIES (circle) AND DATES:

Appendectomy ______________	cardiac bypass ________________	cataracts ___________________________
fracture repair ______________	gall bladder ___________________	hip replacement R L ________________
hernia ________________________	hysterectomy _________________	knee cartilage R L ___________________
knee ligament ________________	knee replacement R L __________	shoulder surgery R L _________________
tonsillectomy ________________	others: _______________________	

____

DO YOU HAVE: (please check)

GENERAL:
☐ cancer of ________________________ ☐ diabetes-insulin dependent
☐ diabetes-diet or medication controlled ☐ thyroid disease ☐ fever ☐ night sweats
☐ rapid weight loss or gain ☐ fatigue ☐ anxiety/panic attacks ☐ depression ☐ jaundice
☐ hepatitis ☐ alcoholism ☐ major injuries ☐ swollen ankles
☐ others:____

EYES/EARS/HEAD:
☐ glaucoma ☐ cataracts ☐ blindness ☐ contacts ☐ partial plate ☐ dentures
☐ hearing loss ☐ hearing aids ☐ migraine headaches
☐ other ____

HEART:
☐ heart attack ☐ chest pain/angina ☐ heart failure ☐ heart murmur ☐ palpitations
☐ rheumatic fever ☐ pacemaker
☐ other ____

LUNGS:
☐ asthma ☐ recurrent bronchitis ☐ emphysema ☐ COPD ☐ TB ☐ pneumonia
☐ shortness of breath at night ☐ pulmonary embolus ☐ shortness of breath with mild exertion ☐ recent exposure to TB
☐ other____

BREASTS:
☐ lump ☐ biopsy ☐ fibrocystic disease ☐ mastectomy
☐ other ____

ABDOMEN:
☐ heartburn ☐ hiatal hernia ☐ GERD ☐ frequent nausea/vomiting ☐ inguinal hernia
☐ liver cirrhosis ☐ peptic ulcer disease ☐ other ______________________________

URINARY TRACT:
☐ recurrent bladder/kidney infections ☐ recent infection ☐ bladder control problems
☐ prostate disease ☐ kidney stones ☐ kidney failure ☐ dialysis ☐ kidney transplant
☐ other : ____

BONE/JOINTS:
☐ rheumatoid arthritis ☐ osteoarthritis ☐ osteoporosis ☐ gout ☐ back pain
☐ joint pains ☐ muscle cramps ☐ fractures
☐ other:____

NEUROLOGICAL
☐stroke ☐paralysis ☐numbness or tingling ☐weakness of arms or legs
☐seizure ☐epilepsy ☐dizzy spells ☐black-out spells ☐memory lapses
☐head injury ☐ Alzheimer's disease
☐other ____

BLOOD/VESSELS
☐ easy bruising ☐excessive bleeding ☐taking bloodthinners:____________________

☐ anemia ☐ blood clots ☐ phlebitis ☐ PVD ☐ sickle cell trait or disease ☐AIDS ☐HIV

☐ blood transfusions ☐other ____

COMMENTS: ____

ANESTHESIA HISTORY: Date of last anesthetic: ____
Have you ever had an adverse reaction/problem with anesthesia? ☐Yes ☐ No
Explain: ____
Have you had blood relatives with anesthesia problems? ☐Yes ☐No
Explain: ____

FAMILY HISTORY: (circle and indicate relative)
Bleeding Tendency _________________ Blood Clots ______________________ Cancer___________________________
Depression _______________________ Diabetes _______________________ Heart Attack ______________________
Heart Disease ____________________ High Blood Pressure _______________ Osteoarthritis _____________________
Rheumatoid Arthritis ______________ Stroke___________________________ TB________________________________
Others: ____

SOCIAL HISTORY:
Occupation:____ Activities: _________________________
Smoke _______ pack of cigarettes daily for _____ years. Quit smoking__________.
Drink ______ (beers, alcoholic drinks, glasses of wine)per (day, week, month, year).
Have you ever been addicted or dependent on drugs or pain medication? ☐Yes ☐No
Are you on a special diet? ☐Yes ☐ No
Type:____

Height: ___________ Weight:_________

Are you pregnant? ☐Yes ☐ No

Name of person completing form if other than patient: ____

AUTHORIZATION:
My signature indicates that I have read the above and grant authorization and I am responsible for payment and fees.

______________________ ____
Date Patient, Parent or legal guardian signature

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