Central Nebraska Orthopedics

ACCT. TYPE_____

DOCTOR _____

DATE_____ AGE_____ DATE OF BIRTH_____ HEIGHT_____ WEIGHT_____ SEX_____

PATIENT'S NAME:_____ SS #_____
LAST FIRST INITIAL SOCIAL SECURITY #

ADDRESS:_____
STREET CITY STATE ZIP CODE

HOME PHONE: (____) _____ SPOUSE/PARENT NAME:_____

CELL PHONE: (____) _____ CELL PHONE: (____) _____

E-MAIL ADDRESS:_____

PATIENT'S EMPLOYER:_____ (____)_____
(IF MINOR, FATHER'S EMPLOYER) Work Phone

EMPLOYER ADDRESS:_____

SPOUSE EMPLOYER: _____ (____)_____
(IF MINOR, MOTHER'S EMPLOYER) Work Phone

EMPLOYER ADDRESS:_____

*IN CASE OF EMERGENCY CONTACT: _____ PHONE: (____) _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ POLICY #: _____ GROUP #: _____
POLICY HOLDER'S NAME: _____ BIRTHDATE: _____ SS #: _____

SECONDARY INSURANCE # _____ POLICY #: _____ GROUP #: _____
POLICY HOLDER'S NAME: _____ BIRTHDATE: _____ SS #: _____

THIRD PARTY: _____ POLICY #: _____ GROUP #: _____
POLICY HOLDER'S NAME: _____ BIRTHDATE: _____ SS #: _____

REASON FOR VISIT: _____ FAMILY PHYSICIAN _____

NAME OF DOCTOR WHO REFERRED YOU: _____ PRIOR X-RAYS FOR PROBLEM: ____ YES ____ NO

PRIOR TREATMENT FOR PROBLEM:_____ WHERE: _____ DATE: _____

IS THIS MEDICAL CONDITION DUE TO AN ACCIDENT OR INJURY? _____YES _____ NO

IF YES WAS IT: ( ) Work Related ( ) Auto ( ) Injured in own home ( ) Other

DATE: _____ PLACE OF INJURY: _____

BRIEF DESCRIPTION OF ACCIDENT_____

_____

HAS FIRST REPORT OF INJURY BEEN FILED WITH EMPLOYER? _____YES _____ NO

ATTORNEY'S NAME:_____ DO YOU HAVE LITIGATION PENDING:____ YES ____ NO

AUTHORIZATION (Assignment of benefits/financial agreement):

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Central Nebraska Orthopedics, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney fees. I hereby authorize Central Nebraska Orthopedics to release all information to insurance companies, attorneys, or other physicians to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

HIPAA PRIVACY NOTICE:

The signature below acknowledges receipt of a copy of Central Nebraska Orthopedics notice of privacy practices.

CONSENT TO MEDICAL TREATMENT:

Knowing that I have (or the patient listed above has) a condition requiring diagnosis and medical treatment, do hereby voluntarily consent to such diagnostic procedures, x-rays and to such medical treatment rendered by Central Nebraska Orthopedics.

Interest at the rate of 16% per annum will be charged on all accounts that remain unpaid 90 days after rendition of the statement of account.

Date:_____ Signature_____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

PLEASE COMPLETE OTHER SIDE OF FORM

Aguilar Printing, Inc.

Patient Intake

Central Nebraska ORTHOPEDICS™
Dedicated to the motion of life

GRAND ISLAND
(800) 782-6959 • (308) 384-5400
West Faidley Medical Center
620 North Diers Ave., Suite 200

HASTINGS
(877) 232-8689 • (402) 462-4241
Crosier Park Professional Center
223 East 14th St., Suite 250

Patient Name:

Birth Date: **Gender:**

Rendering Provider: **MRN:**

Appt Date:

Height: _____

Weight: _____

Blood Pressure: _____

Pain Scale: _____

Chief Complaint: _____

Medical History

Please check if you have ever been diagnosed with the following:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Angina
- ☐ Anxiety/Panic Attacks
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots
- ☐ Cancer, type: _____
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Fibromyalgia
- ☐ GERD(Reflux)
- ☐ Gout
- ☐ Hemophilia/Bleeding Disorder
- ☐ Hepatitis A/B/C
- ☐ High Blood Pressure
- ☐ Irregular Hearbeat
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea

Are there any other medical problems we should know about? _____

Past Surgical History

Check all that apply and indicate which side, R/L as appropriate

- ☐ ACL Surgery, year: ____
- ☐ Angioplasty, year: ____
- ☐ Angio w/ stent, year: ____
- ☐ Arthroscopy, ankle, year: ____
- ☐ Arthroscopy, elbow, year: ____
- ☐ Arthroscopy, hip, year: ____
- ☐ Arthroscopy, knee, year: ____
- ☐ Arthroscopy, shoulder, year: ____
- ☐ Back Surgery, year: ____
- ☐ CABG, year: ____
- ☐ Carpal Tunnel Release, year: ____
- ☐ Cataract Extraction, year: ____
- ☐ Cholecystectomy, year: ____
- ☐ Colectomy, year: ____
- ☐ Colostomy, year: ____
- ☐ Gastric Bypass, year: ____
- ☐ Hernia Repair, year: ____
- ☐ Hip Replacement, year: ____
- ☐ Knee Replacement, year: ____
- ☐ Laminectomy, year: ____
- ☐ LASIK, year: ____
- ☐ Meniscus Surgery, year: ____
- ☐ ORIF, year: ____
- ☐ Pacemaker, year: ____
- ☐ Rotator Cuff Repair, year: ____
- ☐ Thyroidectomy, year: ____
- ☐ Tonsillectomy, year: ____

Gender Specific

- ☐ Hysterectomy
- ☐ Cesarean Section
- ☐ Other surgeries not listed above: _____
- ☐ Breast Biopsy
- ☐ Mastectomy
- ☐ Bilateral Tubal Ligation
- ☐ D&C

Please continue on other side

Family History

Please select conditions affecting immediate family members, immediate family members include parents, siblings and children.

☐ Family History Unknown
☐ No Significant
☐ Diabetes
☐ Osteoporosis
☐ Cancer, type :
☐ Other :

Social History

What is your occupation?

Are you pregnant? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes, How many per day? ☐ No

History of alcohol/drug abuse? ☐ Yes ☐ No

What is your tobacco use history?

Smoker Status: ☐ Current every day smoker ☐ Current some day smoker ☐ Smoker, current status unknown
☐ Never smoker ☐ Former smoker ☐ Unknown if ever smoked

	Current	Former	Never	Amount per day:	Number of Years:
Cigarettes	☐	☐	☐		
Cigar	☐	☐	☐		
Pipe	☐	☐	☐		

	Current	Former	Never	Amount per day:	Number of Years:
Chewing	☐	☐	☐		
Snuff	☐	☐	☐		
Smokeless (Electronic)	☐	☐	☐		

Second-hand smoke exposure: ☐ Yes ☐ No

Review of Systems

Constitutional

Chills:	☐ Yes	☐ No
Fatigue:	☐ Yes	☐ No
Fever:	☐ Yes	☐ No
Night Sweats:	☐ Yes	☐ No
Weight Gain:	☐ Yes	☐ No
Weight Loss:	☐ Yes	☐ No

HEENT

Double Vision:	☐ Yes	☐ No
Headache:	☐ Yes	☐ No
Ringing in Ears:	☐ Yes	☐ No
Vertigo:	☐ Yes	☐ No
Vision Loss:	☐ Yes	☐ No

Respiratory

Chest pain (repiratory)	☐ Yes	☐ No
Cough:	☐ Yes	☐ No
Dyspnea:	☐ Yes	☐ No
Known TB Exposure:	☐ Yes	☐ No
Wheezing:	☐ Yes	☐ No

Metabolic/Endocrine

Cold Intolerant:	☐ Yes	☐ No
Hair Loss:	☐ Yes	☐ No
Heat Intolerant:	☐ Yes	☐ No

Neurological

Difficulty Walking:	☐ Yes	☐ No
Dizziness:	☐ Yes	☐ No
Poor coordination:	☐ Yes	☐ No
Memory Loss:	☐ Yes	☐ No
Paresthesia:	☐ Yes	☐ No
Seizures:	☐ Yes	☐ No
Tremors:	☐ Yes	☐ No

Psychiatric

Anxiety:	☐ Yes	☐ No
Depression:	☐ Yes	☐ No
Insomnia:	☐ Yes	☐ No

Cardiovascular

Chest pain:	☐ Yes	☐ No
Cyanosis (blue digits):	☐ Yes	☐ No
Heart Murmur:	☐ Yes	☐ No
Leg Swelling:	☐ Yes	☐ No
Syncope (fainting):	☐ Yes	☐ No
Irregular Heartbeats:	☐ Yes	☐ No

Gastrointestinal

Abdominal Pain:	☐ Yes	☐ No
Constipation:	☐ Yes	☐ No
Black tarry stools:	☐ Yes	☐ No
Diarrhea:	☐ Yes	☐ No
Heartburn:	☐ Yes	☐ No
Nausea:	☐ Yes	☐ No
Vomiting:	☐ Yes	☐ No

Genitourinary

Dysuria:	☐ Yes	☐ No
Frequent Urination:	☐ Yes	☐ No
Hematuria (blood in urine):	☐ Yes	☐ No

Integumentary

Contact Allergy:	☐ Yes	☐ No
Itchy Skin:	☐ Yes	☐ No
Rash:	☐ Yes	☐ No
Skin Infections:	☐ Yes	☐ No
Skin Lesion:	☐ Yes	☐ No

Musculoskeletal

Back pain:	☐ Yes	☐ No
Bone/Joint Symptoms:	☐ Yes	☐ No
Myalgia:	☐ Yes	☐ No
Muscle Weakness:	☐ Yes	☐ No
Neck Stiffness	☐ Yes	☐ No
Rheumatologic Manifestations:	☐ Yes	☐ No

Hematologic

Bleeding:	☐ Yes	☐ No
Bruising:	☐ Yes	☐ No

Immunological

Asthma:	☐ Yes	☐ No
Contact Dermatitis:	☐ Yes	☐ No
Environmental Allergies:	☐ Yes	☐ No
Food Allergies:	☐ Yes	☐ No

Allergies:_____

_____

Medications:_____

_____

_____

_____

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