DEMOGRAPHIC FORM

Today's date:	☐ Dr. Doug S. Clouse	☐ Dr. Benjamin MacQueen	☐ Dr. D. Gregory Stewart

PATIENT INFORMATION

Name (Last, First, MI):				Marital status (circle one) Single / Mar / Div / Sep / Wid
Home phone no.: ( )	Cell phone no.: ( )	SSN:	Birth date:	Sex: ❑ M ❑ F
Mailing Address:		City & State:		ZIP Code:
Street Address (*if different from above)*:		City & State:		ZIP Code:

E-mail Address:

***☐ Yes, I would like to be able to update my health history and have access to my medical records through OSPI's online patient portal.

Race ☐American Indian or Alaska Native ☐Asian ☐Pacific Islander ☐African American ☐Caucasian ☐Hispanic ☐Other

Ethnicity ☐Hispanic or Latin ☐Not Hispanic or Latin **Language** ☐English ☐Spanish ☐Other

Pharmacy:_____ City:_____ Cross Roads:_____

*Primary Care Physician:*_____ Phone no.:_____

*Referring Physician:*_____ Phone no.:_____

INSURANCE INFORMATION

Are you the primary insured? ☐Yes ☐No. If no please fill out the insurance information below for the primary insured:

Name of primary insured:

SSN:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No		Patient's relationship to the primary insured: ☐Self ☐Spouse ☐Child ☐Other:_____	

Name of Secondary Insurance (if applicable):

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

May staff members in our office speak to these people on your behalf regarding your medical information? ☐Yes ☐No

Emergency Contact Name:	Relationship to patient:	Phone no.: ( )
Emergency Contact Name:	Relationship to patient:	Phone no.: ( )

_____ _____

Patient/Guardian signature *Date*

3530 S. Val Vista Dr. #105 Gilbert, AZ 85297 • 480.899.4333 Fax: 480.899.7219

IMPORTANT OFFICE POLICIES: *Please Read and Sign this Form*

RELEASE OF MEDICAL INFORMATION
I authorize *OSPI Orthopedics* to release and receive the medical records concerning myself/son/daughter to any physician, hospital, insurance carrier, or other agency involved in the care of the patient listed.

RELEASE OF ELECTRONIC MEDICAL INFORMATION
I authorize *OSPI Orthopedics* to release and receive, through software that meets or exceeds the Federal standard for encrypted electronic medical records concerning myself/son/daughter to/from any pharmacy, physician, hospital, insurance carrier, or agency involved in the care of the patient listed.

ASSIGNMENT OF MEDICAL BENEFITS
I request payment under the insurance policy of the card that was presented at the time of service be made directly to the provider listed on any claim for services furnished to myself/son/daughter during the effective period of this authorization. I authorize *OSPI Orthopedics* to release to the Social Security Administration, its intermediaries or carriers, any information required for this claim or any related Medicare or Medicaid claim. I authorize the release of any information necessary to determine these benefits or benefits payable for related services.

PRIVACY PRACTICES AND HIPAA POLICY
I have been offered a copy of *OSPI Orthopedics'* Notice of Health Information Portability Accountability Act, and I understand that my health information will be protected by this act according to the written policy of *OSPI Orthopedics.* I understand that *OSPI Orthopedics* has the right to change this notice from time to time and that I may contact *OSPI Orthopedics* at any time to obtain a current copy.

PAYMENT POLICY
I understand that co-payments are to be collected at the time services are received. The office accepts cash, checks, Visa, American Express, and Master Card. All medical services provided are directly charged to the patient or responsible party. If a physician is contracted with my insurance carrier, the office will accept the negotiated rate for the charges billed. However, I will be responsible for any balance deemed patient responsibility/non-payable/non-covered by my insurance, and I will be billed accordingly. I will pay the full amount upon receipt of a statement, or I will make payment arrangements with the billing office. I agree to pay a $30.00 processing fee for any ***non-sufficient funds check***, and I understand that I am responsible for ***form fees***, $20.00 for the first page and $5 for each additional page, in the event I request forms from an outside party to be filled-out and signed by the physician.

REFERRAL POLICY
I understand that it is my responsibility to obtain a referral through my primary care physician's office if required by my insurance carrier. I understand that if I fail to procure the proper referral that the charges will become my responsibility.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION REGARDING TREATMENT, PAYMENT, AND OTHER OFFICE POLICIES.

Patient/Guardian signature:_____ *Today's Date*:_____

NAME *(Last, First, M.I.):* ☐ M ☐ F	DOB: Age:
HEIGHT: **Weight:** ☐Right Handed ☐Left Handed ☐Amdidextrous	

CURRENT CONDITION

REASON FOR VISIT:

How long ago did this problem start? _____Days _____Weeks _____Months _____Years

Is current problem a result from injury?

☐ No, please state how your symptoms began:_____

☐ Yes, (please circle one): Work Accident Car Accident Sport Other:_____

Date of accident:_____ Specify where and how it happened:_____

Injury occurred from a: ☐Lift ☐Twist ☐Fall ☐Bend ☐Pull ☐Reach ☐Hit by object ☐Unknown ☐Other:_____

Comments: On a scale of 0-10 (10=worst), how sever is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? ☐Sharp ☐Dull ☐Stabbing ☐Throbbing ☐Aching ☐Burning

The pain is now: ☐Constant ☐Comes and goes

Does your pain wake you from sleep? ☐Yes ☐No

Do you have the following? (Check all that supply):
☐Bruising ☐Joints giving away ☐Locking/catching ☐Numbness ☐Swelling ☐Tingling ☐Weakness ☐Painful popping

Since the problem started, it is: ☐Better ☐Worse ☐Same

What makes your problem worse? (Check all that supply): ☐Bending ☐Exercise ☐Kneeling ☐Lifting ☐Sitting ☐Standing
☐Squatting ☐Twisting ☐Walking ☐Overhead activities ☐Other:_____

What is your single most painful activity?_____

What makes your problem better? (Check all that apply): ☐Heat ☐Elevation ☐Ice ☐Rest ☐Other:_____

Have you had a prior problem with this same condition in the past? ☐No ☐Yes. If yes please describe:_____

Review of Systems

Please check all that apply

General/Constitutional Complaints
☐Chills
☐Fatigue
☐Fever
☐Headache
☐Lightheadedness
☐Weight gain
☐Weight loss
☐Night sweats

Cardiovascular
☐Dizziness
☐Shortness of breath
☐Weakness
☐Chest pain at rest

Musculoskeletal
☐Painful joints
☐Pain in shoulder(s)
☐Swollen joints
☐Trauma to arm(s)
☐Trauma to knee(s)
☐Weakness
☐Leg cramps
☐Joint stiffness
☐Carpal tunnel
☐Muscle aches

Endocrine
☐Excessive thirst
☐Frequent urination
☐Difficulty sleeping

Respiratory
☐Cough

Genitourinary
☐Abdominal pain/swelling

Past Medical History
☐Arthritis
☐Atrial fibrillation
☐Depression
☐Carpal tunnel
☐Obesity
☐Heart murmur
☐Anxiety
☐Alcohol abuse
☐Diabetes, type II
☐Stroke
☐Coronary artery disease
☐AIDS/HIV
☐Neck pain
☐Sheehans syndrome
☐Shoulder tendonitis

Tobacco Use/Smoking
☐Current Smoker
  ☐every day
  ☐some days
☐Former smoker
☐Non-smoker

Alcohol Use
Did you have a drink containing alcohol in the past year?
☐Yes ☐No

Exercise
Do you exercise?
☐Yes ☐No

Sports
Do you play sports?
☐Yes ☐No

Family History
<u>Father</u>
☐ Heart Disease
☐Diabetes
☐Obesity
☐Musculoskeletal Problems
☐Reaction to Anesthesia

<u>Mother</u>
☐ Heart Disease
☐Diabetes
☐Obesity
☐Musculoskeletal Problems
☐Reaction to Anesthesia

<u>Siblings</u>
☐ Heart Disease
☐Diabetes
☐Obesity
☐Musculoskeletal Problems
☐Reaction to Anesthesia

HEALTH HISTORY		
SURGERIES	**☐NONE**	**☐ADDITIONAL SHEET ATTACHED**
Year	Reason	

CURRENT MEDICATIONS	**☐NONE**	**☐ADDITIONAL SHEET ATTACHED**
Drug	Strength	Frequency Taken

ALLERGIES	**☐NONE**	**☐ADDITIONAL SHEET ATTACHED**
Food and/or Medication	Reaction	

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient Name:_____

Patient Signature:_____