Date ____________ Next Gen # ____________

FIRST STATE ORTHOPAEDICS

☐ Dr. Axe ☐ Dr. Brady ☐ Dr. Hershey ☐ Dr. Johnson ☐ Dr. Katz ☐ Dr. Moran ☐ Dr. Pushkarewicz ☐ Dr. Rudin ☐ Dr. Steele
☐ Dr. Bodenstab ☐ Dr. Crain ☐ Dr. Hogan ☐ Dr. Kahlon ☐ Dr. Kim ☐ Dr. Newcomb ☐ Dr. Raisis ☐ Dr. Sowa

PATIENT INFORMATION

Name ____________ (LAST) (FIRST) (MI)
Address ____________
Development ____________
City/State/Zip ____________
Home phone ( ) ____________ Cell ( ) ____________
Family Doctor ____________ Phone ( ) ____________
Referring Dr. ____________ Phone ( ) ____________
How did you hear about us? ____________
Referring Attorney Name ____________

Date of birth ____________ Age ____ ☐ Male ☐ Female
☐ Single ☐ Married ☐ Divorced ☐ Widowed
Relationship to responsible person ____________
Social Security No. ____________
Occupation ____________
Employed by ____________
Business phone ( ) ____________

PERSON RESPONSIBLE FOR PAYMENT (IF NOT PATIENT)

Name ____________ (LAST) (FIRST) (MI)
Address ____________
Development ____________
City/State/Zip ____________
Home phone ( ) ____________

Social Security No. ____________
Relationship to Patient ____________
Occupation ____________
Employed by ____________
Business phone ( ) ____________

INSURANCE INFORMATION

PRIMARY

Subscriber's Name ____________ (LAST) (FIRST) (MI)
Insurance Co. Name ____________
Insurance Co. Address ____________
City/State/Zip ____________

Patient's I.D. No. ____________
Group/Account No. ____________
Relationship to patient ____________
Date of birth ____________
Social Security No. ____________

SECONDARY

Subscriber's Name ____________ (LAST) (FIRST) (MI)
Insurance Co. Name ____________
Insurance Co. Address ____________
City/State/Zip ____________

Patient's I.D. No. ____________
Group/Account No. ____________
Relationship to patient ____________
Date of birth ____________
Social Security No. ____________

(✓ Box) ☐ AUTO ACCIDENT ☐ WORK RELATED INJURY ☐ PERSONAL INJURY

Insurance Co. Name ____________
Insurance Co. Address ____________
City/State/Zip ____________
Insurance Co. phone ( ) ____________
Name of Adjuster ____________
Name of Attorney ____________ Phone ( ) ____________

Date of Injury ____________
State in which injury occurred ____________
Claim No. ____________
(Complete the following if accidental injury)
Where Accident Occurred ____________
How Accident Occurred ____________

FIRST STATE ORTHOPAEDICS

WHO MAY WE TALK TO ABOUT YOUR CARE?

You may communicate with the following individuals about my care:

Name	Relationship	Phone #

FIRST STATE SURGERY CENTER / SPINE CARE DELAWARE

The First State Surgery Center and Spine Care Delaware are Ambulatory Surgery Centers owned and operated by Physicians of First State Orthopaedics. While our outpatient surgery centers are an appropriate site for your surgical procedure, there are other facilities in the area where such procedures could also be performed. There will be a separate facility fee for surgeries performed at First State Surgery Center or Spine Care Delaware as there would be from any other facility .

FIRST ASSISTANT AT SURGERY

First State Orthopaedics, P.A., employs board certified physician assistants who are trained to perform the duties of a first assistant at surgery and to assist in the office. Our billing to your insurance carrier may include a fee for the physician assistant.

FINANCIAL RESPONSIBILITY STATEMENT/ INSURANCE ASSIGNMENT

I accept responsibility to insure that payment is made for all services rendered on my behalf. I understand that my insurance policy is a contract between me and my insurance company and that I am responsible to First State Orthopaedics, P.A., for all fee balances determined to be patient responsibility. I acknowledge that it is also my responsibility to obtain a referral from my PCP if required or I will be responsible for payment of FSO fees.

I hereby authorize and direct payment to First State Orthopaedics, P.A., for surgical and/ or medical benefits, if any otherwise payable to me under the terms of any applicable insurance. I authorize the release of any medical information necessary to process claims. I hereby authorize photocopies of this form to be as valid as the original.

First State Orthopaedics, P.A., is hereby authorized to take any legal action which may be necessary either in law or in equity in my name against any insurance company for any and all fee balances, and I covenant and agree to cooperate fully with First State Orthopaedics, P.A., in the presentation of such claims and to furnish all papers and documents necessary in such proceedings and to attend court and testify if First State Orthopaedics, P.A., deems such to be necessary.

In the event of default on any payment due First State Orthopaedics, P.A., which are my responsibility, I agree to pay a cost of collection including attorney fees. Balances not paid within 90 days are subject to collection procedures and a collection fee.

I AGREE TO THE ABOVE CONDITIONS

If the patient is a minor, the parent or legal guardian must sign

______________________________ Signature of patient, parent or legal guardian

______________________________ Date

MEDICARE SIGNATURE ON FILE

"I request that payment of authorized Medicare benefits be made on my behalf to First State Orthopaedics, P.A., for any services furnished me by that physician(s). I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS), which oversees the Medicare program, and its agents any information needed to determine these benefits or the benefits payable for related services."

______________________________ Signed: Medicare Beneficiary

______________________________ Date

THE PATIENT/ GUARANTOR IS RESPONSIBLE FOR ALL ACCOUNT BALANCES AFTER INSURANCE HAS PAID

First State Orthopaedics
www.FirstStateOrtho.com
4745 Ogletown-Stanton Road, Suite 225
Newark, DE 19713
302-731-2888 · Fax 302-731-7049

CERVICAL SPINE INTAKE FORM

Date: ________________ **Name:** __________________________________ **Age:** ________ **FSO MR #:** ________________

REASON FOR VISIT - Ort Home

(Please check all that apply)

Body Part(s): ____ ☐ **Right** ☐ **Left** ☐ **Bilateral**

Complaint: ☐ Pain ☐ Injury ☐ Fracture ☐ Numbness ☐ Swelling ☐ Other: ____________________________

Have you been off work for this problem?: ☐ Yes ☐ No **Dates off work:** ____________________________

Doctors who have treated you for this problem: ____________________ **Did that doctor refer you here?:** ☐ Yes ☐ No

Diagnostic tests and treatment performed *(please list when/where/what)* **:** ☐ X-Ray ______________ ☐ MRI ______________

☐ Injection ____________ ☐ Surgery: ____________ ☐ NSAIDS (anti-inflammatories) ____________ ☐ EMG ____________

☐ CT/Scan ____________ ☐ Bone Scan ____________ ☐ Lab Work ____________ ☐ Other: ____________ ☐ PT ____________

Have you ever had similar problems? If yes, please give details: ____

HISTORY OF PRESENT INJURY - Ortho OV>Specialty HPI>Cervical Spine

(Describe your pain, please check all that apply)

Onset of Pain: ___________ ☐ Wk(s) ☐ Mo(s) ☐ Yr(s)

Severity : ☐ 1 (little pain) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (excrutiating pain)

Date of Injury: __________ ☐ **Auto Accident** ☐ **Workers' Comp**

Status of Pain: ☐ Improved ☐ No change ☐ Worse ☐ Resolved

Work Status: ☐ Currently working _____ hrs/wk ☐ Not working

Frequency of Pain: ☐ Daily ☐ Constant ☐ Intermittent ☐ Occasional

Location of Pain: ☐ Pain Resolved

	R	L	BL
Neck	☐	☐	☐
Arm	☐	☐	☐
Shoulder	☐	☐	☐
Intrascap	☐	☐	☐
Other: ____________			

Radiation of Pain: ☐ None

	R	L	BL
Neck	☐	☐	☐
Trap	☐	☐	☐
Shoulder	☐	☐	☐
Elbow	☐	☐	☐
Arm	☐	☐	☐
Hand	☐	☐	☐
Other: ____________			

Weakness: ☐ None

	R	L	BL
Wrist	☐	☐	☐
Arm	☐	☐	☐
Shoulder	☐	☐	☐
Hand	☐	☐	☐
Finger	☐	☐	☐
Elbow	☐	☐	☐
Other: ____________			

Numbness/Tingling: ☐ None

	R	L	BL
Neck	☐	☐	☐
Trap	☐	☐	☐
Shoulder	☐	☐	☐
Elbow	☐	☐	☐
Arm	☐	☐	☐
Hand	☐	☐	☐
Other: ____________			

Quality of Pain:
- ☐ Severe
- ☐ Aching
- ☐ Shooting
- ☐ Dull
- ☐ Resolved
- ☐ Other ______________

Aggravated By:
- ☐ Lifting
- ☐ Sitting
- ☐ Driving
- ☐ Office Work
- ☐ Sleeping
- ☐ End of Day
- ☐ Mornings
- ☐ Other: ____________

Relieved By:
- ☐ Changing Positions
- ☐ Sitting
- ☐ Heat
- ☐ Exercise
- ☐ Medication: __________
- ☐ Rest
- ☐ Stretching
- ☐ Other: ______________

Associated Symptoms/ Pertinent Negatives:
- ☐ Balance Disturbances
- ☐ Bladder Incontinence
- ☐ Bowel Incontinence
- ☐ Spasms
- ☐ Gait Disturbances
- ☐ Change in Handwriting
- ☐ Difficulty w/ Fine Motor Control
- ☐ Other: ______________

Context

Symptoms Improved With:
☐ PT ☐ Injections ☐ Time ☐ Meds

Symptoms Failed to Improve With:
☐ PT ☐ Injections ☐ Time ☐ Meds

Please check the box below that best describes your pain:
☐ Neck Pain = Arm Pain ☐ Neck Pain > Arm Pain ☐ Neck Pain < Arm Pain

REVIEW OF SYSTEMS - Ortho OV>Add Additional ROS>ROS Defaults>Globally Normal Ortho

Do you have any of the following symptoms? *(Please check all that apply)*

Constitutional:
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats

Cardiovascular:
- ☐ Chest Pain
- ☐ Cyanosis (blue coloration of skin)
- ☐ Irregular Heartbeats/Palpatations

Integumetary/Skin:
- ☐ Rash

Metabolic/Endocrine:
- ☐ Cold Intolerant
- ☐ Heat Intolerant

HEENT:
- ☐ Headache
- ☐ Vision Loss

Gastrointestinal:
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

Neurological:
- ☐ Difficulty Walking
- ☐ Dizziness

Hematologic/Blood:
- ☐ Bleeding

Respitory:
- ☐ Cough
- ☐ Dyspnea

Genitourinary:
- ☐ Dysuria
- ☐ Hematuria

Immunological:
- ☐ Enviromental Allergies
- ☐ Food Allergies

☐ Other: ______________

☐ Other: ______________

☐ Other: ______________

☐ **None**

PATIENT'S MEDICAL CONDITION - Assistant Doc>Vital Signs

Height: ___ft ___in **Weight:** _____lbs. **My Weight in the last 6 months has**: ☐ Not Changed ☐ Increased _____lbs. ☐ Decreased _____lbs.

Please list details of any special diet program: ______________________________

Have you ever taken any anti-inflammatories/arthritis medications?: ☐Yes ☐No (ex: Naprosyn/Ibuprofen) If yes, please list: ______________________

ALLERGIES - Assistant Doc>Add Allergy

(Please check all that apply)

Reaction:	Reaction:	Allergy & Reaction:
☐ Aspirin ____________	☐ NSAIDs ____________ (anti-inflammatories - ibuprofen, naprosyn)	☐ Other: ____________
☐ Codeine ____________	☐ Narcotics ____________ (Percocet, Vicodin)	☐ Other: ____________
☐ IV Dye ____________	☐ Penicillin ____________	☐ Other: ____________
☐ Latex ____________	☐ Sulfa ____________	☐ **No Known Drug Allergies**

PATIENT'S MEDICAL HISTORY - Histories>Additional History

(Please check all that apply)

☐ AIDS/HIV
☐ Alcoholism
☐ Alzheimers
☐ Anemia
☐ Angina
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Benigin Prostatic Hyertrophy
☐ Cancer
☐ Cerebrovascular Accident (Stroke)
☐ Congestive Heart Failure (CHF)
☐ COPD (Emphysema)
☐ Coronary Artery Disease
☐ Crohn's Disease
☐ Degenerative Joint Disease
☐ Depression
☐ Diabetes
☐ Drug Abuse
☐ DVT (Blood Clot)
☐ Fibromyalgia
☐ Gallbladder Disease
☐ GERD
☐ Gout
☐ Hepatitis
☐ High Cholesterol
☐ High Blood Pressure
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Inflammatory Bowel Disease
☐ Juvenile Rheumatoid Arthritis
☐ Kidney Disease
☐ Liver Disease
☐ Lyme Disease
☐ Migraine Headaches
☐ Multiple Sclerosis
☐ Myocardial Infarction
☐ Obesity
☐ Osteoarthritis
☐ Osteoporosis
☐ Parkinson Disease
☐ Peptic Ulcer Disease
☐ Psoriasis
☐ PVD
☐ Renal Disease
☐ Rheumatoid Arthritis
☐ Scoliosis
☐ Seizure Disorder
☐ Sleep Apnea
☐ SLE (Lupus)
☐ Spinal Stenosis
☐ Thyroid Disease
☐ Valvular Disease (Heart valve problems)
☐ **None**
☐ Other: ____________ ____________ ____________ ____________ ____________

PATIENT'S SURGICAL HISTORY - Histories>Additional History

(Please check all that apply)

☐ ACL Surgery
☐ Angioplasty
☐ Angio w/stent
☐ Appendectomy
☐ Athroscopy (Scope) Details: ____________
☐ Back Surgery - Details: ____________ ____________
☐ CABG
☐ Cardiac (Heart) Valve Replacement
☐ Carpal Tunnel Release
☐ Cataract Extraction
☐ Cholecystectomy (gallbladder removal)
☐ Colectomy
☐ Colostomy
☐ Discectomy
☐ Gastric Bypass
☐ Hernia Repair
☐ Hip Replacement
☐ Knee Replacement
☐ Laminectomy
☐ LASIK
☐ Meniscus Surgery
☐ Muscle Biopsy
☐ Neck Surgery - Details: ____________ ____________
☐ ORIF
☐ Pacemaker
☐ Small Bowel Resection
☐ Thyroidectomy
☐ Tonsillectomy

Gender Specific

Female

☐ Cesarean Section
☐ Hysterectomy
☐ Mastectomy

Male

☐ Prostatectomy
☐ TURP

☐ Other: ____________ ____________ ____________ ____________ ____________
☐ **None**

PATIENT'S FAMILY HISTORY - Histories> Additional Family History

Is your Father Living? ☐ Yes ☐ No If no, age deceased ________ cause of death ______________________

Is your Mother Living? ☐ Yes ☐ No If no, age deceased ________ cause of death ______________________

Are any of your brothers/sisters deceased? ☐ Yes ☐ No If yes, age deceased _______ cause of death ______________________

Family history of chronic/inherited diseases: ______________________________

PATIENT'S SOCIAL HISTORY - Histories>Social History

Tobacco Use: ☐ Yes ☐ No ☐ Former/Year Quit _______ **Consume Alcohol**: ☐ Yes ☐ No ☐ Former/Year Quit _______

Activity Level: ☐ Sedentary ☐ Moderate ☐ Vigorous **Type of Exercise**: ____________ ____________

SIGNATURE

Date: ____________ **Signature of Patient, Parent or Guardian:** ______________________

First State Orthopaedics

www.FirstStateOrtho.com
4745 Ogletown-Stanton Road, Suite 225
Newark, DE 19713
302-731-2888 · Fax 302-731-7049

LUMBAR SPINE INTAKE FORM

Date: ________________ **Name:** ________________________________ **Age:** ________ **FSO MR #:** ________________

REASON FOR VISIT - Ort Home

(Please check all that apply)

Body Part(s): ____ ☐ **Right** ☐ **Left** ☐ **Bilateral**

Complaint: ☐ Pain ☐ Injury ☐ Fracture ☐ Numbness ☐ Swelling ☐ Other: ________________________________

Have you been off work for this problem?: ☐ Yes ☐ No **Dates off work:** ________________________________

Doctors who have treated you for this problem: ____________________________ **Did that doctor refer you here?:** ☐ Yes ☐ No

Diagnostic tests and treatment performed *(please list when/where/what)*: ☐ X-Ray ________________ ☐ MRI ________________

☐ Injection ____________ ☐ Surgery: ____________ ☐ NSAIDS (anti-inflammatories) ____________ ☐ EMG ____________

☐ CT/Scan ____________ ☐ Bone Scan ____________ ☐ Lab Work ____________ ☐ Other: ____________ ☐ PT ____________

Have you ever had similar problems? If yes, please give details: ________________________________

HISTORY OF PRESENT INJURY - Ortho OV>Specialty HPI>Lumbar Spine

(Describe your pain, please check all that apply)

Onset of Pain: _____ _____ ☐ Wk(s) ☐ Mo(s) ☐ Yr(s)

Date of Injury: __________ ☐ **Auto Accident** ☐ **Workers' Comp**

Work Status: ☐ Currently working _____ hrs/wk ☐ Not working

Severity : ☐ 1 (little pain) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (excrutiating pain)

Status of Pain: ☐ Improved ☐ No change ☐ Worse ☐ Resolved

Frequency of Pain: ☐ Daily ☐ Constant ☐ Intermittent ☐ Occasional

Location of Pain: ☐ Pain Resolved

	R	L	BL
Lower Back	☐	☐	☐
Leg	☐	☐	☐
Buttock	☐	☐	☐
Groin	☐	☐	☐
Other: ____________			

Radiation of Pain: ☐ None

	R	L	BL
Buttock	☐	☐	☐
Thigh	☐	☐	☐
Ankle	☐	☐	☐
Foot	☐	☐	☐
Great Toe	☐	☐	☐
Other: ____________			

Weakness: ☐ None

	R	L	BL
Hip	☐	☐	☐
Leg	☐	☐	☐
Knee	☐	☐	☐
Foot	☐	☐	☐
Ankle	☐	☐	☐
Other: ____________			

Numbness/Tingling: ☐ None

	R	L	BL
Buttock	☐	☐	☐
Thigh	☐	☐	☐
Ankle	☐	☐	☐
Foot	☐	☐	☐
Great Toe	☐	☐	☐
Other: ____________			

Quality of Pain:
- ☐ Severe
- ☐ Aching
- ☐ Shooting
- ☐ Dull
- ☐ Resolved
- ☐ Other ____________

Context

Symptoms Improved With:
☐ PT ☐ Injections ☐ Time ☐ Meds

Symptoms Failed to Improve With:
☐ PT ☐ Injections ☐ Time ☐ Meds

Aggravated By:
- ☐ Bending
- ☐ Changing Positions
- ☐ Lifting
- ☐ Sitting
- ☐ Driving
- ☐ Walking
- ☐ Standing
- ☐ Pushing
- ☐ End of Day
- ☐ Mornings
- ☐ Other: __________

Relieved By:
- ☐ Changing Positions
- ☐ Sitting
- ☐ Laying Down
- ☐ Standing
- ☐ Heat
- ☐ Exercise
- ☐ Medication: __________
- ☐ Rest
- ☐ Stretching
- ☐ Other: ____________

Associated Symptoms/ Pertinent Negatives:
- ☐ Balance Disturbances
- ☐ Bladder Incontinence
- ☐ Bowel Incontinence
- ☐ Spasms
- ☐ Gait Disturbances
- ☐ Weakness
- ☐ Change in Handwriting
- ☐ Other: ____________

Please check the box below that best describes your pain:
☐ Back Pain = Leg Pain ☐ Back Pain > Leg Pain ☐ Back Pain < Leg Pain

REVIEW OF SYSTEMS - Ortho OV>Add Additional ROS>ROS Defaults>Globally Normal Ortho

Do you have any of the following symptoms? *(Please check all that apply)*

Constitutional:
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats

Cardiovascular:
- ☐ Chest Pain
- ☐ Cyanosis (blue coloration of skin)
- ☐ Irregular Heartbeats/Palpatations

Integumetary/Skin:
- ☐ Rash

Metabolic/Endocrine:
- ☐ Cold Intolerant
- ☐ Heat Intolerant

HEENT:
- ☐ Headache
- ☐ Vision Loss

Gastrointestinal:
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

Neurological:
- ☐ Difficulty Walking
- ☐ Dizziness

Hematologic/Blood:
- ☐ Bleeding

Respitory:
- ☐ Cough
- ☐ Dyspnea

Genitourinary:
- ☐ Dysuria
- ☐ Hematuria

Immunological:
- ☐ Enviromental Allergies
- ☐ Food Allergies

☐ Other: ____________

☐ Other: ____________

☐ Other: ____________

☐ **None**

PATIENT'S MEDICAL CONDITION - Assistant Doc>Vital Signs

Height: ___ft ___in **Weight:** _____lbs. **My Weight in the last 6 months has**: □ Not Changed □ Increased _____lbs. □ Decreased _____lbs.

Please list details of any special diet program: ____________________

Have you ever taken any anti-inflammatories/arthritis medications?: □Yes □No (ex: Naprosyn/Ibuprofen) If yes, please list: ____________________

ALLERGIES - Assistant Doc>Add Allergy

(Please check all that apply)

Reaction:	Reaction:	Allergy & Reaction:
□ Aspirin ____________	□ NSAIDs ____________ (anti-inflammatories - ibuprofen, naprosyn)	□ Other: ____________
□ Codeine ____________	□ Narcotics ____________ (Percocet, Vicodin)	□ Other: ____________
□ IV Dye ____________	□ Penicillin ____________	□ Other: ____________
□ Latex ____________	□ Sulfa ____________	□ **No Known Drug Allergies**

PATIENT'S MEDICAL HISTORY - Histories>Additional History

(Please check all that apply)

□ AIDS/HIV
□ Alcoholism
□ Alzheimers
□ Anemia
□ Angina
□ Arthritis
□ Asthma
□ Atrial Fibrillation
□ Benigin Prostatic Hyertrophy
□ Cancer
□ Cerebrovascular Accident (Stroke)
□ Congestive Heart Failure (CHF)
□ COPD (Emphysema)
□ Coronary Artery Disease
□ Crohn's Disease
□ Degenerative Joint Disease
□ Depression
□ Diabetes
□ Drug Abuse
□ DVT (Blood Clot)
□ Fibromyalgia
□ Gallbladder Disease
□ GERD
□ Gout
□ Hepatitis
□ High Cholesterol
□ High Blood Pressure
□ Hyperthyroidism
□ Hypothyroidism
□ Inflammatory Bowel Disease
□ Juvenile Rheumatoid Arthritis
□ Kidney Disease
□ Liver Disease
□ Lyme Disease
□ Migraine Headaches
□ Multiple Sclerosis
□ Myocardial Infarction
□ Obesity
□ Osteoarthritis
□ Osteoporosis
□ Parkinson Disease
□ Peptic Ulcer Disease
□ Psoriasis
□ PVD
□ Renal Disease
□ Rheumatoid Arthritis
□ Scoliosis
□ Seizure Disorder
□ Sleep Apnea
□ SLE (Lupus)
□ Spinal Stenosis
□ Thyroid Disease
□ Valvular Disease (Heart valve problems)
□ **None**
□ Other:
____
____
____
____
____

PATIENT'S SURGICAL HISTORY - Histories>Additional History

(Please check all that apply)

□ ACL Surgery
□ Angioplasty
□ Angio w/stent
□ Appendectomy
□ Athroscopy (Scope) Details: ____________________
□ Back Surgery - Details: ____________________ ____________________
□ CABG
□ Cardiac (Heart) Valve Replacement
□ Carpal Tunnel Release
□ Cataract Extraction
□ Cholecystectomy (gallbladder removal)
□ Colectomy
□ Colostomy
□ Discectomy
□ Gastric Bypass
□ Hernia Repair
□ Hip Replacement
□ Knee Replacement
□ Laminectomy
□ LASIK
□ Meniscus Surgery
□ Muscle Biopsy
□ Neck Surgery - Details: ____________________ ____________________
□ ORIF
□ Pacemaker
□ Small Bowel Resection
□ Thyroidectomy
□ Tonsillectomy

Gender Specific

Female

□ Cesarean Section
□ Hysterectomy
□ Mastectomy

Male

□ Prostatectomy
□ TURP

□ Other:
____
____
____
____
____
□ **None**

PATIENT'S FAMILY HISTORY - Histories> Additional Family History

Is your Father Living? □ Yes □ No If no, age deceased ________ cause of death ____________________

Is your Mother Living? □ Yes □ No If no, age deceased ________ cause of death ____________________

Are any of your brothers/sisters deceased? □ Yes □ No If yes, age deceased _______ cause of death ____________________

Family history of chronic/inherited diseases: ____________________

PATIENT'S SOCIAL HISTORY - Histories>Social History

Tobacco Use: □ Yes □ No □ Former/Year Quit _______ **Consume Alcohol**: □ Yes □ No □ Former/Year Quit _______

Activity Level: □ Sedentary □ Moderate □ Vigorous **Type of Exercise**: ____________________ ____________________

SIGNATURE

Date: ________________ **Signature of Patient, Parent or Guardian:** ____________________

FIRST STATE ORTHOPAEDICS

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of First State Orthopaedics Notice of Privacy Practices.

____

Print Name

__________________________ ______________

Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of First State Orthopaedics Notice of Privacy Practices but acknowledgment could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (Please Specify)

____

____

____