Baywood Orthopedic Clinic

Please print on this form.

SS# ______________ Patient Name: ____
Last Name First Name Middle Initial

Permanent Address: ____

City: ______________________ State: ______________________ Zip: __________

Local Address: ____

City: ______________________ State: ______________________ Zip: __________

Date of Birth: ______________________ Sex: **Male** **Female** Marital Status: **S M W D**

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Primary Care Physician: ______________________________ PCP Phone: ______________

Patient Employer: ____

Primary Insurance: ______________________

Insurance Co.: ______________________

Policy #: ______________ Group #: __________

Relation to patient: ______________________

Insured's Name: ______________________

Insured's Date of Birth: ______________________

Insured's Employer: ______________________

Insured's SS# ______________________

Secondary Insurance: ______________________

Insurance Co.: ______________________

Policy #: ______________ Group #: __________

Relation to patient: ______________________

Insured's Name: ______________________

Insured's Date of Birth: ______________________

Insured's Employer: ______________________

Insured's SS# ______________________

Who may receive information regarding your Protected Health Information?

Spouse: ______ Name: ______________________________ Date of Birth: ______________

Child: ______ Name: ______________________________ Date of Birth: ______________

Child: ______ Name: ______________________________ Date of Birth: ______________

Child: ______ Name: ______________________________ Date of Birth: ______________

Child: ______ Name: ______________________________ Date of Birth: ______________

Parent / Guardian Name: ______________________________ Date of Birth: ______________

Parent / Guardian Name: ______________________________ Date of Birth: ______________

Significant Other / Friend: ______________________________ Date of Birth: ______________

Significant Other / Friend: ______________________________ Date of Birth: ______________

May we leave messages regarding test results and appointments on your voice mail? Yes: ______ No: ______

I have received a copy of the Baywood Orthopedic Clinic Privacy Policy and authorize the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to Baywood Orthopedic Clinic.

Date:______________ Signature: X ______________ ***Circle:*** **Patient** **Parent** **Guardian**

If you have two insurance companies or Medicare plus a supplemental or replacement policy, please present **BOTH CARDS** so that we may file with your secondary carrier for any benefits due you.

Medical History:

Previous Surgeries / Hospitalizations:

Year: Reason:

Current Medications:

Name: Dose: Times / day:

Allergies: Reaction:

Family History:

Age: Living/Dead: Cause of Death:

Father:

Mother:

Siblings:

Tobacco: **Pipe** **Cigarettes** **Cigars** **Chew**

Alcohol: **Drinks /day ______ /week ______ /month ______**

Height: Weight: Weight 1 year ago:

Misc. Health Information:

Please check if you have or have had any of the following:

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Stroke
- ☐ Cancer Type: ________________
- ☐ Tuberculosis
- ☐ Valley fever
- ☐ Asthma
- ☐ Pneumonia
- ☐ Polio
- ☐ Anemia
- ☐ Jaundice
- ☐ Multiple sclerosis
- ☐ Hepatitis A B C
- ☐ HIV / AIDS

Please check if you have or have had any of the following:

Head / Eyes / Ears / Nose / Throat:

- ☐ Headache
- ☐ Visual changes
- ☐ Glasses / Contact lenses
- ☐ Hearing aide
- ☐ Dizziness
- ☐ Sinus problems
- ☐ Bleeding gums
- ☐ Sore throat

Respiratory:

- ☐ Shortness of breath
- ☐ Cough with phlegm
- ☐ Cough with blood
- ☐ Wear oxygen
- ☐ Abnormal chest x-ray

Explain: ________________

Cardiac:

- ☐ Heart pain
- ☐ Swelling feet
- ☐ Heart murmur
- ☐ Palpitations
- ☐ Abnormal EKG

Explain: ________________

Gastrointestinal:

- ☐ Nausea / Vomiting
- ☐ Loss of appetite
- ☐ Rectal bleeding
- ☐ Difficulty swallowing
- ☐ Indigestion
- ☐ Constipation

Urinary:

- ☐ Inability to pass urine
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Frequent infections
- ☐ Kidney stones

Vascular:

- ☐ Varicose veins
- ☐ Deep vein thrombosis
- ☐ Pulmonary embolus

Psychiatric:

- ☐ Depression
- ☐ Anxiety
- ☐ Mood disturbances

Musculoskeletal:

- ☐ Right ☐ Left handed
- ☐ Joint pain / stiffness
- ☐ Decreased range of motion
- ☐ Arthritis
- ☐ Gout

Hematological:

- ☐ Bleeding tendencies
- ☐ Anemia
- ☐ Previous transfusion

When: ________________

Genital:

- ☐ Sexually transmitted disease
- ☐ Method of contraception:

____

- ☐ Date of last menstrual period:

____

Please include additional information or information you did not have room for on the previous pages:

Optional page.