PATIENT INFORMATION FORM

Date:_____ /_____ /_______ Social Security Number:______________

Name: Mr./Mrs./Ms. ____
First Middle Last

Home Address: ____
Street City State Zip

Home Phone:( ) ______________ Cell:( ) ______________ Email: ____________________

Date of Birth:__________________ Age: ___ Sex: ___ Single ___ Married ___ Divorced ___ Other ________

Employer Name: ______________________________ Address: _____________________________________

Work Phone # ________________________________

Spouse's Name: ______________________ Date of Birth: ________________ SS# _____________________

Home address if different from above: ____

Employers name and address: ____ Phone # _____________

If the patient is a child, responsible party's name and relationship to child if not parent:

Name: ______________________________ Relationship: ________________ SS# _____________________

Date of Birth: ________________________ Employer: ____

Employer Address: ____ Work Phone # _____________

Reason for Visit? ____ Accident? Yes ___ No ___

Work Related? Yes ___ No ___

Did injury occur during school athletic event? Yes ___ No ___ School Name: __________________________

Referring Physician: ____

In Case of emergency contact: ______________________ PhoneNumber: ______________________

Please provide us with your insurance cards and picture ID so we may copy them. If you don't have the cards available you will be responsible for the office fee.

FINANCIAL RESPONSIBILITY AGREEMENT

I understand that my insurance is a contract between the insurance carrier and me, not between the insurance carrier and this office, and that I am fully responsible for all fees. Should timely payments of this account not be made, I authorize Beaufort Orthopaedic and Sports Medicine Center, P.A. to retain the services of any attorney and/or collection agency to assist with the collection of any outstanding balance. Any expense incurred by such action shall become an additional liability for which I assume responsibility.

Signature: ______________________________ Print Name: __________________________ Date: _________

Patient Health Questionnaire

Name: ______________________ Date: ______________ Family Doctor: ______________

Reason for this Office Visit: ____

Previous Hospitalizations & Surgeries (Include Place, Date and Reason whether it's related to today's problem or not) ____

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Current Medications: ____

Allergies: If none state "NONE" ____

Circle YES or NO	Self		Parents		Other Relatives	
Diabetes	YES	NO	YES	NO	YES	NO
Heart Problems (Heart Attack)	YES	NO	YES	NO	YES	NO
High Blood Pressure	YES	NO	YES	NO	YES	NO
Stroke	YES	NO	YES	NO	YES	NO
Tuberculosis	YES	NO	YES	NO	YES	NO
Cancer	YES	NO	YES	NO	YES	NO
Crippling Arthritis	YES	NO	YES	NO	YES	NO
Bleeding Tendancies	YES	NO	YES	NO	YES	NO
Blood Clots	YES	NO	YES	NO	YES	NO
Liver Disease	YES	NO	YES	NO	YES	NO
Kidney Disease	YES	NO	YES	NO	YES	NO
Mental Health Problems	YES	NO	YES	NO	YES	NO
Do you play Sports Activities	YES	NO				
If YES then which Sports?						

Personal History:

If Married, health of spouse: ____

If Single, Do you have family support? YES NO

DO YOU:			How Much?	For How Long?
Smoke	YES	NO	____________	____________
Drink Alcohol	YES	NO	____________	____________
Use Caffeine	YES	NO	____________	____________
Wear Dentures	YES	NO	____________	____________

Patients General Health Recently ____

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