SCRANTON ORTHOPAEDIC SPECIALISTS P.C.

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DATE: _____

Dear _____

Thank you for choosing our orthopaedic practice. This letter is a reminder of your upcoming appointment with Dr. _____ on _____ at _____.

In order to expedite the registration process, we ask you to bring the following:

1. All insurance information (Insurance cards). Also, bring Photo ID
2. If this is a Compensation injury, your Workmen's Comp Claim # and your Compensation Carrier address and phone number.
3. If Auto Accident related, your claim # and address and phone # or carrier.
4. A REFERRAL if you are a managed care participant. (Note: We are NOT allowed to see you if you do not have a referral form from your primary care physician.)
5. Please arrive 15 minutes early to complete paperwork.

We ask you to bring the actual films or copies of X-RAYS, MRI'S, BONE SCANS AND CAT SCANS AS WELL AS THEIR REPORTS, and any other pertinent test results.

If you were seen by another physician for the same problem, we ask that you hand carry any previous records, hospital records (operative reports) and any other reports (for example, nerve conduction studies, vascular studies). Please include any information regarding cortisone or epidural injections.

Enclosed is a history form (health questionnaire). Please bring the completed form with you to your appointment as well as the Authorization Form on the reverse of this page. Please bring an up to date list of your medications from your family doctor.

Payment is due at the time of service for co-payments and non-covered charges. We accept Mastercard, Visa and personal checks. If payment cannot be made at time of service, arrangements must be made with the Business Office at 307-1768 before your visit.

Directions to our office: Exit 190 off Route 81, make right, office is .3 miles on right.

Thank you for your cooperation. We look forward to meeting you.

NEW HIP PROBLEM QUESTIONAIRE

Please circle or fill in completely

Name: Today's Date:

Age: Date of Birth: Sex: M F

Second Opinion? Yes No Pain in which hip? R L Both

Duration of symptoms: years months

Was this problem caused by an injury? Yes No

If yes, describe injury and date:

Location of pain: (circle all that apply)

Groin Buttock Thigh Knee Calf Foot

Pain is described as: (circle all that apply)

Sharp Dull Constant Ache Occasional

Pain is getting: Worse Better Same

Pain at rest? Yes No

Pain intensity: Mild Moderate Severe Intolerable

Please list ALL pain medication taken for this problem and prescribing doctor:

Please list ALL over the counter medication taken for this problem:
(i.e.: Advil, Ibuprofen, Tylenol, Aleve, etc.)

Does the medication help? Yes No

Have you had physical therapy? Yes No Helpful? Yes No
When? Duration of therapy?

Have you tried using a cane or walker? Yes No

How many blocks can you walk before stopping? blocks

Have you had any steriod (cortisone) injections? Yes No

Were they helpful? Yes No

Date of last injection: How many?
Relief lasted for: months weeks None

Does the pain in your hip prevent you from doing your daily activities?
Yes No

What can you not do because of your hips?

Have you had any x-rays or MRIs of your hips? Yes No

Where?
When?

Please list all hip surgeries with date and name of surgeon:

Reviewed by: _____

Date: