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.

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HISTORY (Page 1)

Name: _____ **Today's Date:** _____

Address: _____ City _____, State _____ Zip _____

Phone: Home _____ **Cell** _____ **Work** _____

SS#: _____ **Date of Birth:** _____ **Age:** _____ **Sex** _____

Language spoken _____ **Race/Ethnicity** _____

Referring MD or Person: _____ **Send Report?** _____ **Family MD:** _____ **Send Report?** _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Current problem is the resultof a(n): Check all that apply
_____ **Car Accident** _____ **Work accident** _____ **Accident** _____ **Other** _____

If work accident, describe: _____ **Date of injury** _____

Job Title: _____ **Hand Dominance:** _____
Present Work Status: _____ **Working** _____ **Not Working** _____ **Light Duty**

Past Medical History (List any prior and current illnesses & injuries such as high blood pressure, diabetes, heart problems, cancer etc _____

Prior Surgery and hospitalizations, describe, year, complications: _____

Have you ever had general anesthesia: **No** **Yes**
Have any problems with anesthesia: **No** **Yes** **Describe:** _____

Please list medication you are taking at present and the dosage below:

Medication	Dose	Medication	Dose

I HAVE NO KNOWN ALLERGIES ☐

ALLERGIES: Please list:

Reviewed by: _____ MD Date: _____

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HISTORY (Page 2)

Name: _____ **Today's Date:** _____

Family History
Parents ages and health (if deceased, age at death and cause) describe
_____
_____
_____

Siblings sex, ages and health (if deceased, age at death and cause) describe_____
_____
_____

Family history of (circle if yes) Arthritis, Heart disease, Endocrine disease, Muscular disease, Diabetes, other, describe:
_____
_____
_____

Social History
_____ Employed (occupation)_____ _____ Work in the home _____ Student
_____ Single _____ Married _____ Divorced _____ Separated _____Widowed
Children No Yes# _____
Do you live alone: No Yes
Exercise _____ Daily _____ Weekly _____ Monthly _____ Rarely _____Never
What type of exercise_____
Are you on a special diet: No Yes Describe:_____
History of substance abuse: No Yes What? _____
SMOKING: Current smoker ☐ Smoke every day ☐ Smoke some days ☐ ____ packs/day
Former smoker ☐ Never smoked ☐
Drink alcohol: _____ Daily _____ 1-2X week _____ 1-2X month _____ 1/2x year

Review of Systems
Are you currently having or have you had problems with your:

	Circle		Describe all Yes responses
Eyes	**No**	**Yes**	_____
Ears, Nose, Throat	**No**	**Yes**	_____
Lungs, Breathing	**No**	**Yes**	_____
Digestion, Stomach problems	**No**	**Yes**	_____
Bowel movements	**No**	**Yes**	_____
Bladder problem	**No**	**Yes**	_____
Heart Problems	**No**	**Yes**	_____
Appetite or Weight Change	**No**	**Yes**	_____
Bleeding problems	**No**	**Yes**	_____
Balance problems	**No**	**Yes**	_____
Numbness/tingling	**No**	**Yes**	_____
Joint aches/pains	**No**	**Yes**	_____
Depression, anxiety etc.	**No**	**Yes**	_____
Epilepsy/seizures	**No**	**Yes**	_____
AIDS	**No**	**Yes**	_____

I certify that the above information is true and correct. Signed _____ Date ____

Reviewed by: _____MD Date _____