SONORAN ORTHOPAEDICS

702 E. Bell, Rd Suite 117
Phoenix, AZ 85022
PHONE : (480) 744-4468
FAX: (480) 874-2041

Patient Information

Patient Name _____ Date of Birth _____ Gender: Female ☐ Male ☐

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

SS# _____ Employed By _____

E-mail Address: _____

Height: _____ **Weight:** _____

Preferred Language: check one below ☐ English ☐ Spanish ☐ Other _____

Emergency Contact _ _____ Phone _____

Primary Care Physician _____ Physician Phone: _____ Fax: _____

Preferred Pharmacy, Location & Phone Number _____

Insurance Information

Primary Insurance Company _____ Secondary Insurance Company _____

POLICY HOLDER _____ POLICY HOLDER _____

DATE OF BIRTH _____ DATE OF BIRTH _____

RELATIONSHIP TO PATIENT: _____ RELATIONSHIP TO PATIENT _____

Worker's Compensation Information

Compensation Carrier _____ Claim # _____

Employer's Name _____

Address _____ City _____ State _____ Zip _____

Adjuster's Name _____ Phone _____ Date of Injury _____

Consent to Pay Insurance Benefits / Release of Medical Information

I accept responsibility for all Medical Costs incurred by the above named patient. I authorize payment of any insurance benefits to be made directly to Sonoran Orthopaedics. I authorize the release of any medical information necessary to process all insurance claims.

_____

Signature of Patient or Insured Party if Patient is a Minor **Date**

By request, we can provide these forms in any languages listed via language line interpreting services; Spanish, Chinese, Vietnamese, Korean, Tagalog, Russian, Arabic, French Creole, French, Polish, Portuguese, Italian, German, Japanese, and Persian (Farsi).

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HEALTH QUESTIONNAIRE

(Please complete fully)

Name_____Date:_____

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Other:

Occupation: **Hand Dominant**: ☐ Right ☐ Left

History of Past Illnesses: Have you had:

Diabetes	☐ No	☐ Yes	Heart Disease	☐ No	☐ Yes	Lung Disease	☐ No	☐ Yes
Stroke	☐ No	☐ Yes	Cancer	☐ No	☐ Yes	Hypertension	☐ No	☐ Yes
Kidney Disease	☐ No	☐ Yes						

Other Serious Illness: _____

Previous surgeries? ☐ No ☐ Yes

Please List:

_____

Have any of your blood relatives ever been diagnosed with health issues? ☐ No ☐ Yes

Relationship to yourself	Type of Disease
_____	_____
_____	_____

Do you have allergies to medications? ☐ No ☐ Yes

Please List:

_____	_____

Please list all medications you take on a regular basis, including Aspirin and Aspirin Containing Products:

_____	_____
_____	_____

Do you currently use tobacco? _____No_____ Yes

Do you have an advanced care plan or designated surrogate? _____No_____ Yes

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General:

Recent weight change ☐ No ☐ Yes

Skin:

Rashes ☐ No ☐ Yes
Jaundice ☐ No ☐ Yes
Other, explain: _____

Head, Eyes, Earns, Nose, Throat & Neck:

Double vision ☐ No ☐ Yes
Headaches ☐ No ☐ Yes
Seizures ☐ No ☐ Yes
Dizziness ☐ No ☐ Yes
Hard of Hearing ☐ No ☐ Yes
Thyroid Problems ☐ No ☐ Yes
Other, explain: _____

Respiratory:

Spitting up blood ☐ No ☐ Yes
Asthma / Wheezing ☐ No ☐ Yes
Difficulty breathing ☐ No ☐ Yes
Pleurisy /Pneumonia ☐ No ☐ Yes
Other, explain: _____

Cardiovascular:

Chest pain/angina ☐ No ☐ Yes
Shortness of breath ☐ No ☐ Yes
Difficulty walking (2 blocks) ☐ No ☐ Yes
Heart problems / attacks ☐ No ☐ Yes
Heart arrhythmias ☐ No ☐ Yes
High blood pressure ☐ No ☐ Yes
Heart murmur ☐ No ☐ Yes
Swelling of hands, feet ☐ No ☐ Yes
Other, explain: _____

Hematologic:

Bleeding tendencies ☐ No ☐ Yes
Anemia ☐ No ☐ Yes
Blood disease ☐ No ☐ Yes
Other, explain: _____

Gastrointestinal:

Peptic ulcer ☐ No ☐ Yes
Vomiting blood / food ☐ No ☐ Yes
Gallbladder disease ☐ No ☐ Yes
Liver Problems ☐ No ☐ Yes
Hepatitis ☐ No ☐ Yes
Painful bowel movements ☐ No ☐ Yes
Bleeding w/bowel movements ☐ No ☐ Yes
Black stools ☐ No ☐ Yes
Hemorrhoids ☐ No ☐ Yes
Recent change in bowel habits ☐ No ☐ Yes
Frequent diarrhea ☐ No ☐ Yes
Heartburn ☐ No ☐ Yes
Cramping/pain in abdomen ☐ No ☐ Yes
Does food stick in your throat? ☐ No ☐ Yes
Other, explain: _____

Genitourinary:

Frequent Urination ☐ No ☐ Yes
Burning/painful urination ☐ No ☐ Yes
Blood in urine ☐ No ☐ Yes
Kidney problems ☐ No ☐ Yes
Urinary incontinence within the past 12 months ☐ No ☐ Yes
Other, explain: _____

Locomotor-Musculoskeletal:

Varicose veins ☐ No ☐ Yes
Arthritis ☐ No ☐ Yes
Phlebitis ☐ No ☐ Yes
Other, explain: _____

Neuro-psychiatric:

Loss of consciousness ☐ No ☐ Yes
Convulsions ☐ No ☐ Yes
Fainting spells ☐ No ☐ Yes
Prior Psychiatric history ☐ No ☐ Yes
Other, explain: _____

Gynecological:

Age Periods started: _____ # of days it lasts:_____
# of pregnancies: _____ # of miscarriages:_____
Date of last pap smear: _____# of children:_____
Results: _____
Have you been treated for abnormal pap smears: ☐ No ☐ Yes
Explain treatment:
Have you ever had a pelvic infection? ☐ No ☐ Yes
Have you ever had venereal disease? ☐ No ☐ Yes
Explain:

Do you practice monthly breast exams? ☐ No ☐ Yes

Dear Patient:

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This letter will be used as the acknowledgement that you have received a copy of the Notice of Privacy Practices of Sonoran Orthopaedics. The notice describes your rights and our obligations concerning how we may use information about you and how you may have access to this information.

By signing this form, I acknowledge that I have received a copy of the Notice of Privacy Practices of Sonoran Orthopaedics.

Print Name: _____

Signature _____ Date:_____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____ Date of birth: _____

Provide the names of those whom you agree that information can be provided:

_____
_____
_____

For Office Use Only: ***Office Staff Initials:*** _____

Complete the following only if the patient refuses to sign the Acknowledgement:

Reasons for refusal: _____

_____

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Consent to Receive Text Message Appointment Reminders

By signing below, I authorize Sonoran Orthopedics, and its affiliates to contact me by automated SMS text message for appointment reminders. I understand that message/data rates may apply for such messages under my cell phone plan.

Phone number: _____

Patient, Parent, Guardian, or Authorized Representative Initials: _____

I am under no obligation to authorize Sonoran Orthopedics, or its affiliates, to send me text messages. I may opt-out of receiving these communications at any time by contacting the clinic using the contact information below, or by responding STOP to the text message.

I acknowledge that text messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information.

By signing below, I indicate I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages via automated technology from Sonoran Orthopedics and its affiliates to the phone number that I have provided.

Patient Name: _____ **DOB: _____**

Signature: _____ Date: _____

If not signed by patient, please indicate relationship:

☐ Parent ☐ Guardian ☐ Authorized Representative

Print Name: _____

Clinic Use Only

☐ Patient declined
Date: _____