

**Orthopedic Associates of the Greater Lehigh Valley
Patient Information**

Full Name: _____ Today's Date: _____

Address: _____ Birthdate: _____ Age _____

City: _____ State _____ Zip: _____ Sex: M F Patient's SS# _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

Emergency Contact: Name _____ Phone _____ Relationship _____

Marital Status: S M D W DP Children: _____ Spouse's Name: _____

Preferred Pharmacy: _____ Phone: _____ Fax: _____

Family Physician: _____ Phone: _____

Address: _____

Patient's E-mail address _____

Work Status: Are you working disabled retired student primary home director ?

Occupation: _____

Employer: _____

Address: _____

Type of Work: Check all that apply

heavy labor moderate lifting minimal lifting sedentary repetitive movements

Habits: please check all that apply:

Do you smoke? yes # of packs/day _____ no quit in _____ pipe

Do you drink alcohol? yes no occasional every day had problems with abuse

Any Drug Use? yes no had problems with abuse

Dominant Hand R L

Height: _____ **Weight:** _____

Do you exercise regularly? yes no

weights biking yoga stretching other _____
 running swimming pilates tae kwon do karate

MEDICAL HISTORY

Do you have any medical illnesses? Yes No (like high blood pressure, diabetes, etc.)
(we can supply you with a list to refresh your memory)

If yes, please list:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Do you experience any of the following:

- | | |
|---|--|
| 1. Fevers <input type="checkbox"/> | 6. Nausea or Diarrhea <input type="checkbox"/> |
| 2. Vision Problems <input type="checkbox"/> | 7. Urinary Issues <input type="checkbox"/> |
| 3. Throat Pain <input type="checkbox"/> | 8. Numbness <input type="checkbox"/> |
| 4. Chest Pain <input type="checkbox"/> | 9. Skin Rashes <input type="checkbox"/> |
| 5. Shortness of Breath <input type="checkbox"/> | 10. Depression or Anxiety <input type="checkbox"/> |

Please list all previous surgeries and approximate dates:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please list all medications you are currently taking. If you need more space, use the back:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Are you allergic to medication? yes no

If yes, please list with the type of reaction:

- | | |
|----------|---|
| 1. _____ | → <input type="checkbox"/> nausea <input type="checkbox"/> rash <input type="checkbox"/> hives <input type="checkbox"/> too drowsy <input type="checkbox"/> troubles breathing <input type="checkbox"/> _____ |
| 2. _____ | → <input type="checkbox"/> nausea <input type="checkbox"/> rash <input type="checkbox"/> hives <input type="checkbox"/> too drowsy <input type="checkbox"/> troubles breathing <input type="checkbox"/> _____ |
| 3. _____ | → <input type="checkbox"/> nausea <input type="checkbox"/> rash <input type="checkbox"/> hives <input type="checkbox"/> too drowsy <input type="checkbox"/> troubles breathing <input type="checkbox"/> _____ |
| 4. _____ | → <input type="checkbox"/> nausea <input type="checkbox"/> rash <input type="checkbox"/> hives <input type="checkbox"/> too drowsy <input type="checkbox"/> troubles breathing <input type="checkbox"/> _____ |
| 5. _____ | → <input type="checkbox"/> nausea <input type="checkbox"/> rash <input type="checkbox"/> hives <input type="checkbox"/> too drowsy <input type="checkbox"/> troubles breathing <input type="checkbox"/> _____ |

INSURANCE INFORMATION

Relationship to insured: Self Spouse Child Other _____

Do you have Medicare, Medicaid, or Access? Yes No

If Yes, list here: Name: _____ ID#: _____

Primary	Secondary
Insurance Name:	Insurance Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
ID#:	ID#:
Group #:	Group #:
Cardmember's Name:	Cardmember's Name:
Cardmember's SS#:	Cardmember's SS#:
Cardmember's Birthdate:	Cardmember's Birthdate:

INJURY INFORMATION – IF APPLICABLE

WORK RELATED	AUTO ACCIDENT
Date of Injury:	Date of Injury:
Ins Co Name:	Ins Co Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Claim #:	Claim #:
Representative's Name:	Representative's Name:
Phone #:	Phone #:

Assignments of Benefits:

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to ***Orthopedic Associates of the Greater Lehigh Valley, P.A.*** This assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance company. I hereby authorize said assignee to release any and all information necessary to secure payment.

SIGNATURE: _____
(If minor: PARENT OR GUARIDAN SIGNATURE)

MEDICARE PATIENTS ONLY

Name of beneficiary

Health Insurance Claim Number

“I request that payment of authorized Medicare benefits be made either to me or on my behalf to ***Orthopedic Associates of the Greater Lehigh Valley*** for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.”

Signature: _____

Date: _____