

MT TAM ORTHOPEDICS
Orthopedic Surgery and Sports Medicine

Patient Information

Male Female Marital Status: _____ Date Today: _____ Date of Injury: _____
Name: _____ Date of Birth: _____ Age: _____
Mailing Address: _____ Home Phone # _____
City: _____ State: ____ Zip: _____ Work Number # _____
Social Security: _____ Pharmacy & City Location: _____
Employer: _____ Occupation: _____
Employer Address: _____ City: _____ Zip: _____
Spouse/Parent Name: _____ Phone # _____
In Case of Emergency Notify: _____ Phone # _____

Insurance Information

How are you planning on paying for your visit today with the doctor (check **ONE** only)

Medical Insurance: _____ Workman Compensation Insurance/Claim: _____

Privately Paying/Cash: _____ Motor Vehicle Insurance/Claim: _____

Subscriber or Policy Holder: _____ Subscriber Birthdate: _____
Name as it appears on insurance card: _____
Relationship to subscriber/insured: _____ Subscriber Social Security # _____
Insurance Carrier: _____ Phone # _____
Claim Address: _____ City: _____ State: ____ Zip: _____
Insurance I.D.# _____ Group/Plan # _____
Secondary Insurance: _____

Patient Medical & Social History

Primary Care Physician (PCP): _____ Injured Body Part: _____
Present **Medications** taken regularly: _____

Allergies to Medications: _____

Prior and current illnesses and injuries:

List all surgeries and hospitalizations:

Alcohol: Don't Drink: _____ Quantity Socially: _____ Quantity Daily: _____
Tobacco: Don't Smoke: _____ Smoker: _____ # of Years: _____ # of Packs: _____
Sports/Hobbies/Activities: _____
Special Needs: _____
Primary Language: _____

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to my physician (Mt. Tam Orthopedics). I understand I am financially responsible for non-covered services and also authorize my physician to release any information required.

Signature: _____

General Medical History

Are you currently having or have you ever had a problem with the following:

	Yes	No	Describe all "Yes" responses
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung/Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcer or Stomach Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
GI Bleed	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia or other Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis/Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Medical Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have you ever had problems with general anesthesia? Yes No

Family History

Does your immediate family have a history of any of the following medical conditions?

	Yes	No	Relationship
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____

Thank you for completing this form!