Phoenix Orthopedic Group
Patient Registration Form

Patient Name: _____ SS#: _____

Sex: [ ] Male [ ] Female Birthdate: _____ Age: _____ Marital Status: _____

Address: _____ City &State _____ Zip _____

Email Address: _____ (This will imply permission to contact you by email)

Please indicate your preferred phone number by checking in the corresponding box. Keep in mind we may be required to contact you outside of normal business hours.

[] Home Phone: _____ [] Office Phone: _____ [] Cell Phone: _____

Were you injured on the job? [ ] Yes [ ] No Auto Accident? [ ] Yes [ ] No Date of Injury: _____

Referring Doctor: _____ Primary Care Physician: _____

Responsible Party Name: _____ Relationship: _____

Your Employer and Address: _____

Your Spouse's Employer: _____

Are you pregnant? Yes [ ] No [ ]

Medical Information

Preferred Pharmacy: _____

What are you being seen for: _____ Date of First Symptoms: _____

Insurance Information

Insured's Name: _____ Insured's Date of Birth: _____

Relationship: _____

Primary Insurance: _____ Claim's Address: _____

Policy Number: _____ Group Number: _____ Phone: _____

Secondary Insurance: _____ Insured's Name: _____ Insured's Date of Birth: _____

Policy Number: _____ Group Number: _____ Phone: _____

Claim's Address: _____

Authorizations

I hereby authorize Phoenix Orthopedic Group to release any information require in the course of my treatment. I authorize payment directly to the business offices above for surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for all charges not covered by my insurance.

Signed Patient: _____ Date: _____

Guarantor if parent for child over 18: _____ Date: _____

Phoenix Orthopedic Group
Patient History Form

Today's Date:_____DOB: _____ Age: _____

Patient's Name:_____ Sex: M [ ] F [ ] Dominant Hand: R [ ] L [ ]

Occupation: _____

Who Referred You? _____ Primary Care Physician:_____

Problem to be treated today: [ ] Right [ ] Left _____

Location of Pain:_____

When Occured:_____ Where Occurred:_____

How Occurred:_____

_____

Previous/Similar Conditions:_____

Did you have X-rays taken? [ ]Yes [ ] No When:_____Where:_____

Previous Treatment To Date:_____

Alleviated by: _____

Exacerbated by: _____

Have you tried any of the following treatments?

	Yes	Duration?	No
Non-Narcotic Medication (Ibuprofen, Exc.)	[ ]	_____	[ ]
Narcotic Medication (Percocet, Exc.)	[ ]	_____	[ ]
Home Exercises	[ ]	_____	[ ]
Activity Modification	[ ]	_____	[ ]
Rest	[ ]	_____	[ ]
Ice	[ ]	_____	[ ]
Physical Therapy	[ ]	_____	[ ]
MRI	[ ]	_____	[ ]
Injections	[ ]	_____	[ ]

PLEASE CHECK ONLY SIGNIFICANT PROBLEMS

[ ] None	[ ] Aching	[ ] Goes Elsewhere	[ ] Electrical	[ ] Sharp	[ ] Knife-Like
[ ] Burning	[ ] Periodic	[ ] Dull	[ ] Shooting	[ ] Spasmodic	[ ] Throbbing
[ ] At Night	[ ] During Activity	[ ] After Activity	[ ] Tingling	[ ] Grinding	[ ] Tenderness
[ ] Dislocation	[ ] Popping	[ ] Giving Way	[ ] Numbness	[ ] Paralysis	[ ] Soreness
[ ] Stiffness	[ ] Swelling	[ ] Weakness	[ ] Limited Range of Motion		

[ ] Other _____

CURRENT MEDICATIONS AND DOSAGE: [ ] None _____

_____

If you are taking Herbals or Over-the-Counter drugs, please list: [ ] None _____

_____

DRUG ALLERGIES AND REACTIONS: [ ] None_____

Phoenix Orthopedic Group
Patient History Form

Today's Date:_____DOB: _____ Age: _____

Patient's Name:_____ Sex: M [ ] F [ ] Dominant Hand: R [ ] L [ ]

Occupation: _____

Who Referred You? _____ Primary Care Physician:_____

Problem to be treated today: [ ] Right [ ] Left _____

Location of Pain:_____

When Occured:_____ Where Occurred:_____

How Occurred:_____

_____

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Activity Modification	[ ]	_____	[ ]
Rest	[ ]	_____	[ ]
Ice	[ ]	_____	[ ]
Physical Therapy	[ ]	_____	[ ]
MRI	[ ]	_____	[ ]
Injections	[ ]	_____	[ ]

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[ ] Dislocation	[ ] Popping	[ ] Giving Way	[ ] Numbness	[ ] Paralysis	[ ] Soreness
[ ] Stiffness	[ ] Swelling	[ ] Weakness	[ ] Limited Range of Motion		

[ ] Other _____

CURRENT MEDICATIONS AND DOSAGE: [ ] None _____

_____

If you are taking Herbals or Over-the-Counter drugs, please list: [ ] None _____

_____

DRUG ALLERGIES AND REACTIONS: [ ] None_____

HOSPITALIZATIONS: [ ] NONE

Description: _____ Year: _____ Hospital: _____
Description: _____ Year: _____ Hospital: _____
Description: _____ Year: _____ Hospital: _____
Description: _____ Year: _____ Hospital: _____

SURGERIES: [ ] NONE

Description: _____ Year: _____ Hospital: _____
Description: _____ Year: _____ Hospital: _____
Description: _____ Year: _____ Hospital: _____
Description: _____ Year: _____ Hospital: _____

MEDICAL HISTORY/ PROBLEM:

	Personal	Details	Family History	Details
High Blood Pressure	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Heart Problems/ Disease	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Diabetes	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Anemia	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Gout	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Kidney	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Bladder	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Bleeding Disorder	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Asthma	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Epilepsy/ Seizures	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Stomach Problems	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Neurological Disease	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Stroke	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Blindness/ Glaucoma	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Thyroid Problems	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Deafness	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Mental Illness	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Ulcer	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Bowel Problems	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Rheumatic Fever	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
TB	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Valley Fever	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Hepatitis (if yes, which one)	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Pneumonia	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Arthritis	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Phlebitis	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Prostate Problems	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Emphysema	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____
Aids/ HIV	[ ] Y	[ ] N _____	[ ] Y	[ ] N _____

Other: _____

Maritial Status: [ ] S [ ] M [ ] W [ ] D

Do You Smoke? [ ] Yes [ ] No

Alcohol Usage: [ ] None [ ] Socially [ ] Daily

Are You, or Could You be Pregnant? [ ] Yes [ ] No

EMERGENCY CONTACT:

Name: _____ Daytime Phone: _____

Do you authorize this office to discuss your care or treatment with any party besides yourself?

[ ] Spouse [ ] Other: _____

The above information is to the best of my knowledge a true statement of my current physical condition:

Signed: _____ Date: _____

CONSENT TO TREAT A MINOR:

I hereby give my consent for treatment:

Signed: _____ Date: _____
(Legal Guardian)

Phoenix Orthopedic Group, PC

Robert Mileski, M.D.

Patient Questionnaire

Patient Name: _____ **Date of Birth:** _____

REVIEW OF SYSTEMS:

If any of these apply to the patient, please circle the specific problem and provide a brief explanation.

Yes No ***Constitutional:*** fever, unexplained weight loss/weight gain, fatigue, night sweats: _____

_____

Yes No ***Eyes:*** double vision, glasses, blurred vision: _____

Yes No ***Ears, Nose, Mouth, and Throat:*** earache, ringing in the ears, tinnitus, frequent nose-bleeds, congestion, sore throat, hoarseness, loose teeth: _____

Yes No ***Cardiovascular:*** blood pressure, chest pain or discomfort, irregular heartbeats: _____

_____

Yes No ***Respiratory:*** wheezing, chronic cough, coughing up blood, excessive snoring, any difficulty breathing:

_____

Yes No ***Gastrointestinal:*** heartburn, vomiting, nausea, constipation, abdominal pain, change in bowel habits:

_____

Yes No ***Genitourinary:*** painful urination, blood in urine, urinary urgency, problems with prostate, complications with birth control: _____

Yes No ***Musculoskeletal:*** (in addition to the problem we are treating you for today) aching muscles or joints, swelling joints, muscle cramping or spasms, stiffness, weakness: _____

Yes No ***Skin:*** rash, itching, poor wound healing: _____

Yes No ***Neurologic:*** headaches, poor balance, numbness, tingling, fainting, seizures: _____

Yes No ***Psychiatric:*** anxiety, depression, bipolar: _____

Yes No ***Hematologic/ Lymphatic:*** swollen nodes, excessive bruising or bleeding: _____

Yes No ***Allergic/ Immunologic:*** seasonal allergies, persistent infections, HIV exposure: _____

Yes No ***Disabled:*** How and when: _____

INJURY/ ACCIDENT DETAIL FORM

For any answer marked YES, please provide full details (please print).

PATIENT NAME: _____ DATE: _____

Are you being seen for a work related injury? YES NO
IF SO, PLEASE DESCRIBE HOW THE ACCIDENT OR INJURY OCCURRED:

_____

_____

_____

Are you being seen for an auto related injury? YES NO
IF SO, PLEASE DESCRIBE HOW THE ACCIDENT OF INJURY OCCURRED:

_____

_____

_____

Are you being seen for an injury OTHER than auto/ work related? YES NO
DESCRIBE:

_____

_____

_____

Is there other insurance involved? YES NO

NAME OF INSURANCE: _____
MAILING ADDRESS: _____
CLAIM NUMBER: _____ PHONE NUMBER: _____
CONTACT PERSON/ ADJUSTER: _____

Is there an attorney involvement? YES NO

NAME: _____ PHONE NUMBER: _____

Patient Signature: _____

Parent/ Legal Guardian Signature (if minor): _____