PATIENT ID # ___________________

(Please Leave Blank)

Please Use BLACK INK

WELCOME TO NORTHWEST IOWA BONE, JOINT & SPORTS SURGEONS, P.C.

PATIENT'S NAME ____
Last First Middle

ADDRESS _________________________________CITY______________________STATE_____ZIP________

TELEPHONE__________________________SOCIAL SECURITY #_________________________________

SEX_______ BIRTHDATE______________ AGE_______ MARITAL STATUS M___S___W___D___Sep____
M / D / Y

PATIENT/*PARENT __________________________SPOUSE______________________________________
*(If Patient is a Minor)

Birthdate_____________________________________Birthdate____________________________________

Occupation___________________________________Occupation____________________________________

Employer_____________________________________ Employer_____________________________________

Telephone (work)______________________________Telephone (work)_____________________________

Social Security #______________________________Social Security #______________________________

NEAREST FRIEND/RELATIVE OTHER THAN SPOUSE WE MAY CONTACT IN CASE OF EMERGENCY

Name________________________________Relationship___________________________Phone_____________

IFYOU DO NOT HAVE INSURANCE, MAKE ARRANGEMENTS AT DESK
- IF YOU HAVE INSURANCE PLEASE COMPLETE THE FOLLOWING SECTION –
PLEASE PRESENT **ALL** INSURANCE CARDS TO RECEPTIONIST FOR PHOTOCOPYING.

Insurance Company Name__________________________ Subscriber's Date of Birth________________________

If more than one insurance which one is primary? ____

Is this a Worker's Compensation claim? Yes____ No____ Date of Injury____________________________________

Employer________________________________Address____

Accident Related? Auto? Other?

Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Date of Accident_____________________

Are you represented by an attorney regarding this injury? Yes ☐ No ☐

Name of Attorney _______________________Address __________________________ Phone___________________

Accident Insurance Company__________________________Policy Holder_________________Policy#___________

PERSONAL PHYSICIAN/REFERRING PHYSICIAN_________________________**ADDRESS**________________________

I do hereby voluntarily consent to permit any associated physician, therapist or assistant of **NWIA Bone, Joint & Sports Surgeons, PC** to perform diagnostic procedures and such medical treatment or procedures as is necessary or advisable in their judgment for my medical care. I authorize **NWIA Bone, Joint, & Sports Surgeons, PC** to release medical information per HIPPA regulations about me to my insurance company or to my attorney or other doctor's office. I authorize direct payment of medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to **NWIA Bone, Joint & Sports Surgeons, PC**. I understand that I am fully responsible and guarantee payment of services rendered by anyone in this office. I also permit a copy of this authorization be used in place of the original. This assignment will remain in effect until revoked by me in writing.

Date__________________ Signature of Patient (or guardian if minor)____

MEDICAL HISTORY INFORMATION

Name of Patient: ____
(Please Print)

PRESENT HISTORY:
What is your chief complaint for this visit? ______________________________

Date of Accident or onset of symptoms ______________________________

Describe how your symptoms started (if due to injury, how were you injured?) ______________________

____

Have you had any treatment for this condition to date? ________Yes ________ No

If yes, please indicate treatment by marking appropriate box below.

☐ Hospitalization ☐ Surgery ☐ Therapy ☐ Medication ☐ X-rays ☐ Injections

Date__________________________ By Whom ______________________________

Have you ever had similar symptoms prior to this episode? ________Yes ________No

If yes, when ________________ How was it treated? ______________________

Are you working at this time? ________ Yes ________ No Any restrictions? ________Yes ________No

If yes, please list restrictions ______________________________

Last work day ______________________________

FAMILY HISTORY:
Is there a family history of: ________ High Blood Pressure ________ Heart Disease ________ Diabetes

________ Cancer ________ Anesthesia Problems

SOCIAL HISTORY:
Do you smoke? ________ Yes ________ No How Much? ______________________

How often do you drink alcohol? ______________ How many drinks at a time? ______________

Your Weight ______________ Your Height ______________

PERSONAL MEDICAL HISTORY:
Have you ever had any of the following? (Please answer Yes or No)

Breathing Problems	Yes ☐ No ☐	Kidney Problems	Yes ☐ No ☐	Heart Disease	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Ulcers	Yes ☐ No ☐	Hepatitis	Yes ☐ No ☐
Stroke	Yes ☐ No ☐	AIDS	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐
Blood transfusion	Yes ☐ No ☐			Diabetes	Yes ☐ No ☐
Have you ever been told you have a blood antibody?	Yes ☐ No ☐			Bone Densitometry	Yes ☐ No ☐

PLEASE LIST MEDICATION ALLERGIES:______________________________

Other Allergies: ______________________________ **Latex Allergy**: Yes___ No___

Current Medications: ______________________________

____

All Other Medical Problems & Previous Surgeries ______________________________

____