# Central Nebraska Orthopedics

ACCT. TYPE_____

ACCT. # _____

DOCTOR _____

DATE_____ AGE_____ DATE OF BIRTH_____ HEIGHT_____ WEIGHT_____ SEX_____

PATIENT'S NAME:_____ SS #_____
LAST FIRST INITIAL SOCIAL SECURITY #

ADDRESS:_____
STREET CITY STATE ZIP CODE

HOME PHONE: ( _____ ) _____ SPOUSE/PARENT NAME:_____

CELL PHONE: ( _____ ) _____ CELL PHONE: ( _____ ) _____

PATIENT'S EMPLOYER:_____ ( _____ )_____
(IF MINOR, FATHER'S EMPLOYER) Work Phone

EMPLOYER ADDRESS:_____

SPOUSE EMPLOYER: _____ ( _____ )_____
(IF MINOR, MOTHER'S EMPLOYER) Work Phone

EMPLOYER ADDRESS:_____

*IN CASE OF EMERGENCY CONTACT: _____ PHONE: ( _____ ) _____

## INSURANCE INFORMATION

PRIMARY INSURANCE: _____ POLICY #: _____ GROUP #: _____
POLICY HOLDER'S NAME: _____ BIRTHDATE: _____ SS #: _____

SECONDARY INSURANCE # _____ POLICY #: _____ GROUP #: _____
POLICY HOLDER'S NAME: _____ BIRTHDATE: _____ SS #: _____

THIRD PARTY: _____ POLICY #: _____ GROUP #: _____
POLICY HOLDER'S NAME: _____ BIRTHDATE: _____ SS #: _____

**REASON FOR VISIT:** _____ FAMILY PHYSICIAN _____

NAME OF DOCTOR WHO REFERRED YOU: _____ PRIOR X-RAYS FOR PROBLEM: ____ YES ____ NO

PRIOR TREATMENT FOR PROBLEM:_____ WHERE: _____ DATE: _____

**IS THIS MEDICAL CONDITION DUE TO AN ACCIDENT OR INJURY?** _____YES _____ NO

**IF YES WAS IT:** ( ) Work Related ( ) Auto ( ) Injured in own home ( ) Other

DATE: _____ PLACE OF INJURY: _____

BRIEF DESCRIPTION OF ACCIDENT_____

_____

HAS FIRST REPORT OF INJURY BEEN FILED WITH EMPLOYER? _____YES _____ NO

ATTORNEY'S NAME:_____ DO YOU HAVE LITIGATION PENDING:____ YES ____ NO

## AUTHORIZATION (Assignment of benefits/financial agreement):

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Central Nebraska Orthopedics, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney fees. I hereby authorize Central Nebraska Orthopedics to release all information to insurance companies, attorneys, or other physicians to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

## HIPAA PRIVACY NOTICE:

The signature below acknowledges receipt of a copy of Central Nebraska Orthopedics notice of privacy practices.

## CONSENT TO MEDICAL TREATMENT:

Knowing that I have (or the patient listed above has) a condition requiring diagnosis and medical treatment, do hereby voluntarily consent to such diagnostic procedures, x-rays and to such medical treatment rendered by Central Nebraska Orthopedics.

Interest at the rate of 16% per annum will be charged on all accounts that remain unpaid 90 days after rendition of the statement of account.

Date:_____ Signature_____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

**PLEASE COMPLETE OTHER SIDE OF FORM**

# Patient Intake

Central Nebraska ORTHOPEDICS™
Dedicated to the motion of life

**GRAND ISLAND**
(800) 782-6959 • (308) 384-5400
West Faidley Medical Center
620 North Diers Ave., Suite 200

**HASTINGS**
(877) 232-8689 • (402) 462-4241
Crosier Park Professional Center
223 East 14th St., Suite 250

**Patient Name:**

**Birth Date:** **Gender:**

**Rendering Provider:** **MRN:**

**Appt Date:**

## Medical History

*Please check if you have ever been diagnosed with the following:*

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Angina
- ☐ Anxiety/Panic Attacks
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots
- ☐ Cancer, type: _____
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Fibromyalgia
- ☐ GERD(Reflux)
- ☐ Gout
- ☐ Hemophilia/Bleeding Disorder
- ☐ Hepatitis A/B/C
- ☐ High Blood Pressure
- ☐ Irregular Hearbeat
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea

Are there any other medical problems we should know about? _____

## Past Surgical History

*Check all that apply and indicate which side, R/L as appropriate*

- ☐ ACL Surgery, year: ☐☐☐☐
- ☐ Angioplasty, year: ☐☐☐☐
- ☐ Angio w/ stent, year: ☐☐☐☐
- ☐ Arthroscopy, ankle, year: ☐☐☐☐
- ☐ Arthroscopy, elbow, year: ☐☐☐☐
- ☐ Arthroscopy, hip, year: ☐☐☐☐
- ☐ Arthroscopy, knee, year: ☐☐☐☐
- ☐ Arthroscopy, shoulder, year: ☐☐☐☐
- ☐ Back Surgery, year: ☐☐☐☐
- ☐ CABG, year: ☐☐☐☐
- ☐ Carpal Tunnel Release, year: ☐☐☐☐
- ☐ Cataract Extraction, year: ☐☐☐☐
- ☐ Cholecystectomy, year: ☐☐☐☐
- ☐ Colectomy, year: ☐☐☐☐
- ☐ Colostomy, year: ☐☐☐☐
- ☐ Gastric Bypass, year: ☐☐☐☐
- ☐ Hernia Repair, year: ☐☐☐☐
- ☐ Hip Replacement, year: ☐☐☐☐
- ☐ Knee Replacement, year: ☐☐☐☐
- ☐ Laminectomy, year: ☐☐☐☐
- ☐ LASIK, year: ☐☐☐☐
- ☐ Meniscus Surgery, year: ☐☐☐☐
- ☐ ORIF, year: ☐☐☐☐
- ☐ Pacemaker, year: ☐☐☐☐
- ☐ Rotator Cuff Repair, year: ☐☐☐☐
- ☐ Thyroidectomy, year: ☐☐☐☐
- ☐ Tonsillectomy, year: ☐☐☐☐

## Gender Specific

- ☐ Hysterectomy
- ☐ Cesarean Section
- ☐ Other surgeries not listed above: _____
- ☐ Breast Biopsy
- ☐ Mastectomy
- ☐ Bilateral Tubal Ligation
- ☐ D&C

## Family History

*Please select conditions affecting immediate family members, immediate family members include parents, siblings and children.*

☐ Family History Unknown
☐ No Significant
☐ Diabetes
☐ Osteoporosis
☐ Cancer, type :
☐ Other :

## Social History

What is your occupation?

Are you pregnant? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes, How many per day? ☐ No

History of alcohol/drug abuse? ☐ Yes ☐ No

What is your tobacco use history?

Smoker Status: ☐ Current every day smoker ☐ Current some day smoker ☐ Smoker, current status unknown
☐ Never smoker ☐ Former smoker ☐ Unknown if ever smoked

| | Current | Former | Never | Amount per day: | Number of Years: |
|---|---|---|---|---|---|
| Cigarettes | ☐ | ☐ | ☐ | | |
| Cigar | ☐ | ☐ | ☐ | | |
| Pipe | ☐ | ☐ | ☐ | | |

| | Current | Former | Never | Amount per day: | Number of Years: |
|---|---|---|---|---|---|
| Chewing | ☐ | ☐ | ☐ | | |
| Snuff | ☐ | ☐ | ☐ | | |
| Smokeless (Electronic) | ☐ | ☐ | ☐ | | |

Second-hand smoke exposure: ☐ Yes ☐ No

## Review of Systems

### Constitutional

| | | |
|---|---|---|
| Chills: | ☐ Yes | ☐ No |
| Fatigue: | ☐ Yes | ☐ No |
| Fever: | ☐ Yes | ☐ No |
| Night Sweats: | ☐ Yes | ☐ No |
| Weight Gain: | ☐ Yes | ☐ No |
| Weight Loss: | ☐ Yes | ☐ No |

### HEENT

| | | |
|---|---|---|
| Double Vision: | ☐ Yes | ☐ No |
| Headache: | ☐ Yes | ☐ No |
| Ringing in Ears: | ☐ Yes | ☐ No |
| Vertigo: | ☐ Yes | ☐ No |
| Vision Loss: | ☐ Yes | ☐ No |

### Respiratory

| | | |
|---|---|---|
| Chest pain (repiratory) | ☐ Yes | ☐ No |
| Cough: | ☐ Yes | ☐ No |
| Dyspnea: | ☐ Yes | ☐ No |
| Known TB Exposure: | ☐ Yes | ☐ No |
| Wheezing: | ☐ Yes | ☐ No |

### Metabolic/Endocrine

| | | |
|---|---|---|
| Cold Intolerant: | ☐ Yes | ☐ No |
| Hair Loss: | ☐ Yes | ☐ No |
| Heat Intolerant: | ☐ Yes | ☐ No |

### Neurological

| | | |
|---|---|---|
| Difficulty Walking: | ☐ Yes | ☐ No |
| Dizziness: | ☐ Yes | ☐ No |
| Poor coordination: | ☐ Yes | ☐ No |
| Memory Loss: | ☐ Yes | ☐ No |
| Paresthesia: | ☐ Yes | ☐ No |
| Seizures: | ☐ Yes | ☐ No |
| Tremors: | ☐ Yes | ☐ No |

### Psychiatric

| | | |
|---|---|---|
| Anxiety: | ☐ Yes | ☐ No |
| Depression: | ☐ Yes | ☐ No |
| Insomnia: | ☐ Yes | ☐ No |

## Cardiovascular

| | | |
|---|---|---|
| Chest pain: | ☐ Yes | ☐ No |
| Cyanosis (blue digits): | ☐ Yes | ☐ No |
| Heart Murmur: | ☐ Yes | ☐ No |
| Leg Swelling: | ☐ Yes | ☐ No |
| Syncope (fainting): | ☐ Yes | ☐ No |
| Irregular Heartbeats: | ☐ Yes | ☐ No |

## Gastrointestinal

| | | |
|---|---|---|
| Abdominal Pain: | ☐ Yes | ☐ No |
| Constipation: | ☐ Yes | ☐ No |
| Black tarry stools: | ☐ Yes | ☐ No |
| Diarrhea: | ☐ Yes | ☐ No |
| Heartburn: | ☐ Yes | ☐ No |
| Nausea: | ☐ Yes | ☐ No |
| Vomiting: | ☐ Yes | ☐ No |

## Genitourinary

| | | |
|---|---|---|
| Dysuria: | ☐ Yes | ☐ No |
| Frequent Urination: | ☐ Yes | ☐ No |
| Hematuria (blood in urine): | ☐ Yes | ☐ No |

## Integumentary

| | | |
|---|---|---|
| Contact Allergy: | ☐ Yes | ☐ No |
| Itchy Skin: | ☐ Yes | ☐ No |
| Rash: | ☐ Yes | ☐ No |
| Skin Infections: | ☐ Yes | ☐ No |
| Skin Lesion: | ☐ Yes | ☐ No |

## Musculoskeletal

| | | |
|---|---|---|
| Back pain: | ☐ Yes | ☐ No |
| Bone/Joint Symptoms: | ☐ Yes | ☐ No |
| Myalgia: | ☐ Yes | ☐ No |
| Muscle Weakness: | ☐ Yes | ☐ No |
| Neck Stiffness | ☐ Yes | ☐ No |
| Rheumatologic Manifestations: | ☐ Yes | ☐ No |

## Hematologic

| | | |
|---|---|---|
| Bleeding: | ☐ Yes | ☐ No |
| Bruising: | ☐ Yes | ☐ No |

## Immunological

| | | |
|---|---|---|
| Asthma: | ☐ Yes | ☐ No |
| Contact Dermatitis: | ☐ Yes | ☐ No |
| Environmental Allergies: | ☐ Yes | ☐ No |
| Food Allergies: | ☐ Yes | ☐ No |

Allergies:_____

_____

Medications:_____

_____

_____

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_____

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_____