

PARK PLAZA ORTHOPAEDICS

PLEASE CHECK WHICH DR. YOU ARE HERE TO SEE:

DR. CHRISTENSEN     DR. LEE     DR. HADNOTT

DATE: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_ DRIVERS LICENSE #: \_\_\_\_\_

NAME: \_\_\_\_\_  MALE     FEMALE  
(LAST)                      (FIRST)                      (M.I.)

ADDRESS: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_  
(STREET, CITY, STATE, ZIP CODE)                      CELL: ( ) \_\_\_\_\_

IS YOUR RESIDENCE A SKILLED NURSING FACILITY, NURSING HOME OR ASSISTED LIVING COMPLEX?  
 YES     NO

MARITAL STATUS:     SINGLE     MARRIED     WIDOWED     DIVORCED

DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_                      AGE: \_\_\_\_\_

PATIENTS EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMP ADDRESS: \_\_\_\_\_ EMP PHONE: ( ) \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ EMP PHONE: \_\_\_\_\_

IF A MINOR: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ SS#: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_ SS#: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

WHO IS YOUR PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

INSURANCE INFORMATION

PRIMARY CARD HOLDER: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SS#: \_\_\_\_\_

PRIMARY INSURANCE CO: \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_ ELIGIBILITY PHONE #: \_\_\_\_\_

CLAIMS ADDRESS: \_\_\_\_\_

IS THIS AN HMO? \_\_\_\_\_ IF YES, DID YOU BRING YOUR REFERRAL? \_\_\_\_\_

SECONDARY INSURANCE CO: \_\_\_\_\_

GROUP #: \_\_\_\_\_ POLICY #: \_\_\_\_\_

IF THIS A WORK COMP CLAIM PLEASE COMPLETE THE FOLLOWING

DATE OF INJURY: \_\_\_\_\_ EMPLOYER AT TIME OF INJURY \_\_\_\_\_

**PLEASE SIGN**

I HEREBY AUTHORIZE SAID INSURANCE COMPANY (IES) TO PAY DIRECT TO PARK PLAZA ORTHOPAEDIC ASSOCIATES, DR. CECIL CHRISTENSEN, DR. JONATHAN LEE OR DR. W. HADNOTT ALL BENEFITS DUE FOR THE SERVICES PROVIDED BY ANY OF THESE DOCTORS. I HEREBY AUTHORIZE THE NECESSARY MEDICAL INFORMATION TO BE RELEASED TO THE INSURANCE COMPANY (IES) FOR PROCESSING THE CLAIM. PHOTOSTATIC COPIES OF THIS AUTHORIZATION WILL BE CONSIDERED AS VALID AS THE ORIGINAL.

PATIENT / AUTHORIZED REPRESENTATIVE: \_\_\_\_\_

DATE: \_\_\_\_\_

WHAT IS YOUR COMPLAINT? (DESCRIBE BRIEFLY AND SPECIFY LEFT OR RIGHT)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WAS THIS A RESULT OF AN ACCIDENT?  Y  N  
WAS IT AT  HOME  AUTOMOBILE  WORK  OTHER

HAVE YOU HAD XRAYS/MRI TAKEN OF THIS INJURY OR PROBLEM? \_\_\_\_\_  
DATE TAKEN \_\_\_\_\_  
WHERE WERE THEY TAKEN? \_\_\_\_\_

WHICH OF THE FOLLOWING MEDICAL PROBLEMS PERTAIN TO YOU OR A CLOSE FAMILY MEMBER?

TUBERCULOSIS	You/Fam <input type="checkbox"/> <input type="checkbox"/>	HEPATITIS	You/Fam <input type="checkbox"/> <input type="checkbox"/>	CANCER	You/Fam <input type="checkbox"/> <input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/> <input type="checkbox"/>	HEART PROBLEMS	<input type="checkbox"/> <input type="checkbox"/>	WHERE? _____	
THYROID PROBLEMS	<input type="checkbox"/> <input type="checkbox"/>	DIABETES	<input type="checkbox"/> <input type="checkbox"/>	GASTRO INTESTINAL	
BLEEDING PROBLEMS	<input type="checkbox"/> <input type="checkbox"/>	ASTHMA	<input type="checkbox"/> <input type="checkbox"/>	BLEEDING	<input type="checkbox"/> <input type="checkbox"/>
IRREGULAR HEART BEAT	<input type="checkbox"/> <input type="checkbox"/>	TRANSFUSIONS	<input type="checkbox"/> <input type="checkbox"/>	RHEUMATOID ARTHRITIS	<input type="checkbox"/> <input type="checkbox"/>
				LUPUS	<input type="checkbox"/> <input type="checkbox"/>

HAVE YOU BEEN DIAGNOSED WITH HIV/AIDS? \_\_\_\_\_

HAVE YOU HAD ANY PREVIOUS ORTHOPEDIC SURGERIES? IF SO PLEASE DESCRIBE:

\_\_\_\_\_  
\_\_\_\_\_

ANY OTHER MEDICAL PROBLEMS YOU HAVE BEEN TREATED FOR OR HAD SURGERY FOR?

\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST DATES OF HOSPITALIZATIONS: \_\_\_\_\_

PLEASE LIST ALL MEDICATION ALLERGIES: \_\_\_\_\_

PLEASE LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING, INCLUDING ASPIRIN AND OTHER OVER THE COUNTER MEDICATIONS:

\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ALL NATURAL OR HERBAL MEDICATIONS YOU ARE TAKING (AS IN GINSING, GINGKO BILOBA, SLIMFAST, ST. JOHNS WORT, GLUCOSAMINE CHONDROITIN, SULFATES, ETC.):

\_\_\_\_\_  
\_\_\_\_\_

DO YOU SMOKE? \_\_\_\_\_ IF SO, HOW MUCH? \_\_\_\_\_

DO YOU DRINK ALCOHOL? \_\_\_\_\_ IF SO, HOW MUCH? \_\_\_\_\_

IS THERE POSIBILITY YOU ARE PREGNANT? \_\_\_\_\_ DATE OF LAST MENSTRUAL CYCLE? \_\_\_\_\_

DO YOU KNOW YOUR BLOOD TYPE? \_\_\_\_\_ TYPE? \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

HAVE YOU EVER HAD A BONE DENSITY TEST?  YES  NO

IF YES, WHEN WAS THE LAST ONE? \_\_\_\_\_

IS THERE ANY OTHER MEDICAL CONDITION THAT HAS NOT BEEN LISTED THAT YOU WOULD LIKE THE DOCTOR TO BE AWARE OF? \_\_\_\_\_