



North Texas Orthopaedic & Spine History

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

Chief Complaint

Why are you seeing the doctor today? _____

Current problem is the result of a(n): **Check** all that apply

- Car Accident Work Accident Sudden onset Gradual onset Other

Past Medical History

Please describe ALL medical problems (ex: diabetes, hypothyroidism, cancer, apnea, heart conditions)

Past Surgical History

Surgeries/Hospitalizations	Year	Complications?

Have you ever had and problems with anesthesia? No/Yes Describe _____

Please list all medications you are currently taking:

Medication	Dose	Reason For Medication	Side Effects

Additional Room for meds:

Are all immunizations up to date? Yes No

If no, which immunizations are due? _____

MEDICATION ALLERGIES/REACTIONS (please list ALL):

Social History

Work in the home Employed (occupation _____) Student Daycare Retired

Single Married Divorced Separated Widowed

Children? No Yes # _____

Do you live alone? No Yes _____

Exercise? Daily Weekly Monthly Rarely Never

What type of exercise?

History of substance abuse? No Yes What? _____

Smoke currently? No Yes ___ Packs per day for ___ years.

Quit smoking? This year >1 year >5 years >10 years

Previously smoked ___ packs per day for ___ years.

Drink alcohol? Daily 1-2 x/week 1-2 x/month 1-2 x/year

Review of Systems

Are you **currently having** or **have you had** problems with:

	Circle	Describe all "Yes" responses
Eyes	No Yes	_____
Ears, Nose, Throat	No Yes	_____
Lungs, Breathing	No Yes	_____
Digestion	No Yes	_____
Bowel movement	No Yes	_____
Bladder problem	No Yes	_____
Diabetes	No Yes	_____
High blood pressure	No Yes	_____
Heart	No Yes	_____
Bleeding problems	No Yes	_____
Balance problems	No Yes	_____
Numbness/tingling	No Yes	_____
Blackout/fainting	No Yes	_____
Psychological problems	No Yes	_____
HIV/AIDS	No Yes	_____
Cancer (any kind)	No Yes	_____
Arthritis (where)	No Yes	_____
Polio	No Yes	_____
TB	No Yes	_____
Hepatitis	No Yes	_____

Patient Signature: _____

Date: _____

Reviewed By: _____ MD

Date: _____



Welcome to North Texas Orthopaedic & Spine
 4510 Medical Center Drive, Suite 312
 McKinney, Texas 75069

Name: _____ Today's Date: _____
 First Middle Last

How did you learn about our practice? _____

Home Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Cell: _____
 Date of Birth: _____ Age: _____ Email Address: _____
 Occupation: _____ SSN: _____
 Employer: _____ Years There: _____
 Employer's Address: _____
 City: _____ State: _____ Zip: _____
 In case of emergency contact: _____ Relationship: _____
 Home Phone: () _____ Work Phone: () _____

[Primary Insurance]

Name of Insurance Company: _____
 Insured's Name: _____ Relationship to insured _____
 Insured's date of birth _____ Insured's SSN _____
 Group Number: _____ Policy ID Number: _____

[Secondary Insurance]

Name of Insurance Company: _____
 Insured's Name: _____ Relationship to insured _____
 Insured's date of birth _____ Insured's SSN _____
 Group Number: _____ Policy ID Number: _____

I do not have insurance and will be paying my charges in full today.

Did your injury happen on the job? Yes No

If yes, on what date did the injury occur? _____

Did you report the accident to your employer? Yes No

Ins/Workers Comp Carrier _____ Claim # _____

Case Manager: _____ Contact Phone # _____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers.
Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

Signature of Patient or Responsible Party: _____ Date: _____

I authorize the release of any medical information necessary to process my claim.

Signed: _____
 (Patient or responsible party)

I authorize payment of medical and surgical benefits to _____, MD.

Signed: _____
 (Patient or responsible party)