

Total Orthopaedic Care Demographic Sheet

Date: [ ]

Patient's Last Name: [ ] First: [ ]

Home Address: [ ]

City, State, Zip: [ ]

Date of Birth: [ ] Marital Status: [ ]

Home Phone: [ ] Social Security: [ ] Language: [ ]

Cell Phone: [ ] Email: [ ]

Emergency Contact Name: [ ] Contact Number: [ ]

Patient's Employer: [ ] Work Phone: [ ]

Pharmacy Name: [ ] Pharmacy Number: [ ]

Primary Care Physician: [ ]

Primary Insurance Name: [ ] Policy Number: [ ]

Insured Name: [ ] Relationship: [ ]

Insured's Date of Birth: [ ] Insured's Sex:  M  F

Secondary Insurance Name: [ ] Policy Number: [ ]

Insured Name: [ ] Relationship: [ ]

Insured's Date of Birth: [ ] Insured's Sex:  M  F

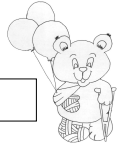
Are you covered by any other insurance do to spouse, work, or alternative coverage?  Y  N [ ]

<p style="text-align: center;"><b>Auto Accident</b></p> <p>Were you the? <input type="checkbox"/> Driver <input type="checkbox"/> Passenger (Front seat)  <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger (Back Seat)</p> <p>Impact Direction? <input type="checkbox"/> Front End <input type="checkbox"/> Rear End  <input type="checkbox"/> Passenger Side <input type="checkbox"/> Driver Side</p> <p>Were you wearing a seatbelt? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Did you hit your head on the: <input type="checkbox"/> Dashboard <input type="checkbox"/> Windshield</p> <p>Did you hit the Steering Wheel? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Did you Lose Consciousness? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Did the Airbag Deploy? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>List other areas of impact: [ ]</p>	<p style="text-align: center;"><b>Attorney</b></p> <p>Do you have an attorney as a result of this injury? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Name of Attorney: [ ]</p> <p>Address: [ ]</p> <p>Phone: [ ]</p> <p>Fax: [ ]</p>
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I hereby consent to and authorize a physician and/or health care professional of T.O.C. to perform a physical examination, diagnostic procedure, and to prescribe a therapeutic regimen. I hereby authorize the physicians of T.O.C. to release any information including diagnosis acquired in the course of my exam to any health care facilities, physicians, insurance carriers, or collection agencies.

I hereby authorize my insurance carrier to pay directly to T.O.C. the medical benefits otherwise payable to me for their services, but not exceed the charges of those services. I hereby irrevocably assign to T.O.C. any benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in the Florida statues for any service and/or charges provided by T.O.C.

The staff at T.O.C. is authorized to call me at the above listed numbers. If I am not available, they are permitted to leave a message with whomever answers or an answering machine / voice mail. I further understand that I am fully responsible for service provide that are not covered by my insurance.



Patient's Name:

Age:  Height:  Weight  Sex:  M  F  Right /  Left Handed

What **Orthopaedic** problem is your child having today?

How long has your child had this problem?

Has your child ever had pain, discomfort, or similar symptoms in this area before?  Y  N

Explain:

Was this caused by an injury?  Y  N Injury Date:

Is this Injury **Work Related**  Y  N Is this related to an **auto accident**  Y  N

If caused by injury, where did injury occur:

How did the injury occur?

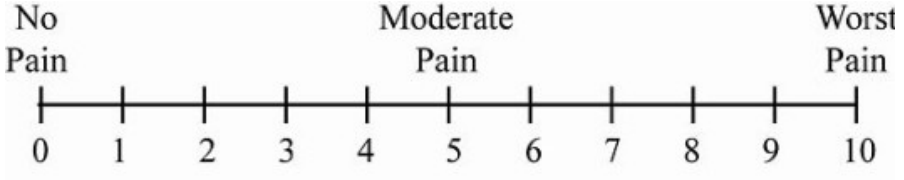
When you first noticed this problem or pain, what were you doing?

Who accompanies the child to this appointment?  Mother  Father  Sibling  Grandparent  Other

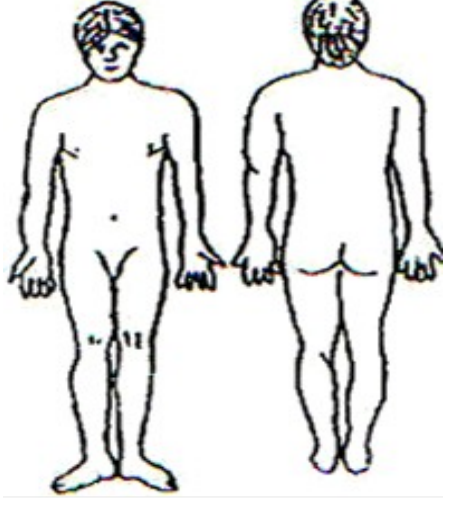
How were you referred to our office?

Pcp (name)	Hospital/ER (name)	Urgent Care (name)
Insurance Directory (name)	Work Comp (name)	Other (name)

On a scale of one to ten, how severe is your child's pain?



Please Mark Problem Areas



Right Left Left Right

Please describe your pain:

<input type="checkbox"/> Aching, like a toothache	<input type="checkbox"/> Radiating or spreading
<input type="checkbox"/> Burning, hot or on fire	<input type="checkbox"/> Sensitive, raw
<input type="checkbox"/> Cold, like ice, or freezing	<input type="checkbox"/> Sharp, like a knife, spike, or piercing
<input type="checkbox"/> Cramping, squeezing or tight	<input type="checkbox"/> Shooting or zapping
<input type="checkbox"/> Electrical, shocks, lightening, or sparking	<input type="checkbox"/> Tingling, pins and needles, prickling
<input type="checkbox"/> Heavy, pressure or weighed down	<input type="checkbox"/> Throbbing or pounding
<input type="checkbox"/> Itchy, like a mosquito bite	<input type="checkbox"/> Unpleasant, annoying, bothersome
<input type="checkbox"/> Numb or asleep	

How Consistent is your Pain? (Choose one)

<input type="checkbox"/> Intermittent (Pain sometimes, but not all the time)	<input type="checkbox"/> Variable (Background pain all the time, but moments of severe pain)	<input type="checkbox"/> Stable (Constant pain all the time that doesn't change much)	<input type="checkbox"/>
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Have you had any treatment for *this* problem?

<input type="checkbox"/> Medication	<input type="checkbox"/> Cat Scan	<input type="checkbox"/> Other, Please list below:
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Bone Scan	
<input type="checkbox"/> Injections	<input type="checkbox"/> Blood Work	
<input type="checkbox"/> X-rays	<input type="checkbox"/> Neurology Consult	
<input type="checkbox"/> MRI	<input type="checkbox"/> Pain Management Consult	



Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Does your child have or has your child had any of these symptoms in the last two weeks?

Symptoms	Yes	No	Explain	Symptoms	Yes	No	Explain
<b>Constitutional</b>				<b>Integumentary</b>			
Fever	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Skin Rash	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Chills	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Boils	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Headaches	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Persistent Itch	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
<b>Eyes</b>				<b>Musculoskeletal</b>			
Blurred Vision	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Joint pain	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Double Vision	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Neck Pain	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Eye Pain	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Back Pain	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
<b>Allergic/Immunologic</b>				<b>Ear/Nose/Throat/Mouth</b>			
Hay Fever	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Ear Infection	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Drug Allergies	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Sore Throat	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Sinus Problem	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
<b>Neurological</b>				<b>Genitourinary</b>			
Tremors	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Urine Retention	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Dizzy Spells	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Painful Urination	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Numbness/tingling	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Urinary Frequency	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
<b>Endocrine</b>				<b>Respiratory</b>			
Excessive thirst	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Wheezing	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Too hot / cold	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Frequent Cough	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Tired / sluggish	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Shortness of Breath	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
<b>Gastrointestinal</b>				<b>Hematologic/Lymphatic</b>			
Abdominal pain	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Swollen Glands	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Nausea/ vomiting	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Blood Clotting Problem	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Indigestion/heartburn	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	<b>Psychological</b>			
<b>Cardiovascular</b>				Are you under the care of a mental health professional?			
Chest Pain	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Do you feel depressed?	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
Varicose veins	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>	Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>
High Blood Pressure	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>				
Other	Y <input type="checkbox"/>	N <input type="checkbox"/>	<input type="text"/>				

Patient's Signature \_\_\_\_\_

Physician Initials \_\_\_\_\_

**Please dictate any positives and how the condition is being treated.**