*Please present ALL Insurance cards and Drivers License at time of visit
COMPLETE ALL Fields as best as possible

Patient Information

Name: (First)______________________________ (MI)_____ (Last)____

Date of Birth: ___________ **Age:** ___ **Gender:**_________ **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widow

Mailing Address: ____

City: _________________________________ **State:** _____ **Zip:** ________ **Social Security#:** _____________________

Home Phone: __________________ **Cell:** ____________________ **Email address:** ____________________________

Occupation: ___________________________ **Employer:** ____________________ **Work Phone:**_________________

Employer Address: ____

Pharmacy Name: ___________________________ **Town:** __________________**Phone#:**_______________________

Primary Care Physician: ____________________ **Town:** _________________ **Phone#:**________________________

Referred by: ☐ Friend/Family ☐ Physical therapist/Chiropractor____________ ☐ Attorney______________ ☐ Other

Referring Physician: ________________________ **Town:** _________________ **Phone#:**______________________

Emergency Contact Name: ___________________ **Relationship:** ____________**Phone#:**______________________

Primary Insurance Plan:_____________________________________**ID#**_______________________________________

Address:____

Primary Insurance Plan Holder's Name:_____________________ **DOB:**___________ **Relationship to patient:**___________

Mailing address of Plan Holder if different from patient: ____

Home Phone of Plan Holder: ________________________ **Cell phone of Plan holder:** ______________________________

Secondary Insurance Plan: ____________________________________**ID#**_______________________________________

Address: ____

Secondary Insurance Plan Holder's Name:_____________________ **DOB:**_________ **Relationship to patient:**___________

Patient Release: **MUST BE SIGNED BY PATIENT** : I understand that Sun Orthopaedic and Spine Care, LLC will prepare any necessary paperwork needed to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Sun Orthopaedic and Spine Care, LLC will be credited to my account.

I understand that any person who knowingly files a statement of claim containing any false or misleading information or knowingly presents any fraudulent information such as personal identification or invalid insurance information is subject to civil and criminal penalties.

I understand and agree that all services rendered to me will be billed to my insurance and that I am responsible for payment. I also hereby authorize Sun Orthopaedic and Spine Care, LLC staff to release any information pertinent to my case concerning illness, condition, or disability and treatment thereof, to any insurance company, adjuster, or attorney involved in this case. I also give permission to leave messages at the insurance companies' and/or attorneys' phone numbers regarding my file AND at the above home or work phone numbers regarding scheduling of appointments and care.

Patient Signature: ____ Date: ___________________

If you are being seen as the result of an Auto Accident or Worker's Compensation case,
COMPLETE ALL Fields as best as possible

Auto Accident / Workers Comp

Name: (First)________________________________ (MI)_____ (Last)____

Were you in an accident: ☐ Motor Vehicle ☐ Workers Comp ☐ Fall ☐ Lifting ☐ Other:______________________

Date of Accident/Injury ____________________ **Location of Accident/Injury** ____________________

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other:______________________

ATTORNEY INFORMATION

Attorney's Name:____ **Attorney Phone #:**__________________________

Attorney's Firm:____

INSURANCE INFORMATION

Insurance Company:____

Claim #: _______________________ **Policy #:** ____________________

Insurance Co. Billing Address: ____

Insurance Co. City: ________________________ **City:** ______________________ **State:**______ **Zip:**____________

Claims Rep Name: ____

Claims Rep Phone#:________________________________

Case Manager:____ **Case Manager Phone:**_________________________

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I understand and agree that all services rendered to me will be billed to my insurance and that I am responsible for payment. I also hereby authorize Sun Orthopaedic and Spine Care, LLC staff to release any information pertinent to my case concerning illness, condition, or disability and treatment thereof, to any insurance company, adjuster, or attorney involved in this case. I also give permission to leave messages at the insurance companies' and/or attorneys' phone numbers regarding my file AND at the above home or work phone numbers regarding scheduling of appointments and care.

Patient Signature: ____ Date: ___________________

SUN ORTHOPAEDIC & SPINE CARE

CHIEF COMPLAINT

Reason for visit: CERVICAL/NECK/ARM LUMBAR/BACK/LEG SCOLIOSIS SHOULDER KNEE OTHER________

When did your condition start? (M/D/Y) _____ /______ /______

Please describe the reason(s) for your visit today: ________________________________

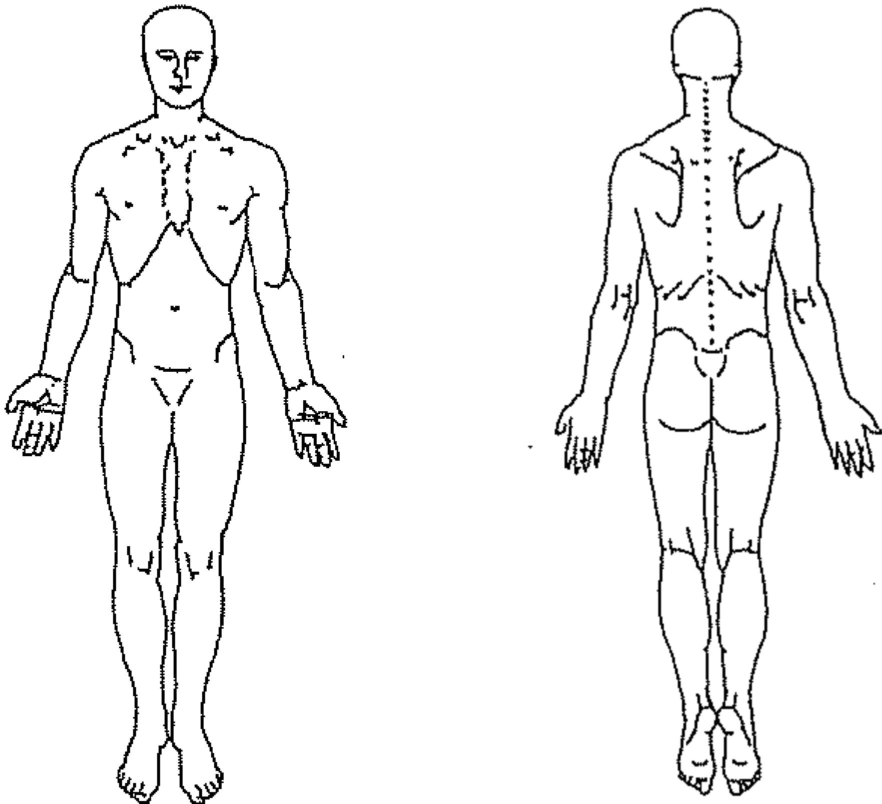
____

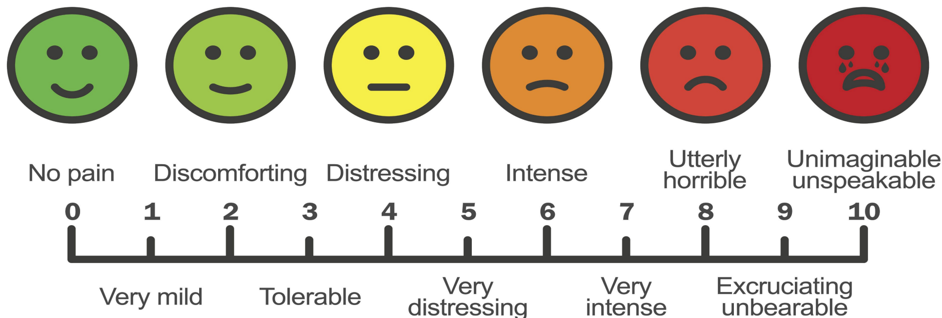
____

Which side ☐RIGHT ☐LEFT ☐BOTH **What is your dominant side**: ☐RIGHT ☐LEFT ☐AMBIDEXROUS

Where are you experiencing pain?

- Please indicate **P** for pain, **N** for Numbness, **T** for Tingling in each area. Shade area as needed to show full area of pain
- If multiple locations please indicate where pain is most severe.





SUN ORTHOPAEDIC & SPINE CARE

If you have had other Orthopedic / Spine injuries or surgeries, please describe:

Orthopedic / Spine injury: ____

Orthopedic / Spine surgery:____

Describe the quality of the pain (check all that apply): ☐DULL ☐ACHY ☐SHARP ☐BURNING ☐TINGLING

Is the pain constant or intermittent? ☐CONSTANT ☐INTERMITTENT

Associated symptoms (check all that apply**)** ☐PAIN AT NIGHT ☐STIFFNESS ☐SWELLING

☐INSTABILITY ☐WEAKNESS ☐NECK/BACK PAIN ☐RADIATING PAIN ☐NUMBNESS/TINGLING

What makes it better? ___________ **What makes it worse?** ___________

Have you had prior studies?

☐X-RAY Date:_____/_____/_____ Facility:__________ Body part:__________

☐MRI Date:_____/_____/_____ Facility:__________ Body part:__________

☐CT SCAN Date:_____/_____/_____ Facility:__________ Body part:__________

☐EMG Date:_____/_____/_____ Facility:__________ Body part:__________

CURRENT MEDICATIONS (list all medications, vitamins, supplements)

Name	*Dose/Frequency*	*Name*	*Dose/Frequency*
1.		4.	
2.		5.	
3.		6.	

KNOWN ALLERGIES (list any allergies and reaction):__________________ ☐**No Known Drug Allergy**

Are you allergic to... Iodine: ☐Yes ☐No **Latex**: ☐Yes ☐No **Metal**, **jewelry, or nickel**: ☐Yes ☐No

Are you currently on any blood thinners? ☐No ☐Yes If yes, which one: ____________________

Have you been taking opioids for 6+ months ? ☐No ☐Yes

PAST SURGICAL HISTORY AND/OR HOSPITALIZATION

Type of operation / reason for hospitalization

1. ____
2. ____
3. ____

Have you ever had a problem with anesthesia and/or surgery ? ☐Yes ☐No Problem:____________

Have you ever had a MRSA infection anywhere ? ☐Yes ☐No

Do you have any of the following medical devices (check any that apply) ?

☐ Pain pump ☐Neurostimulator/Spinal cord stimulator ☐Pacemaker/Defibrillator ☐Shunt for hydrocephalus

SUN ORTHOPAEDIC & SPINE CARE

MEDICAL HISTORY (CHECK any past or current medical conditions below**)**

☐Anxiety	☐Diabetes	☐Infection	☐Pulmonary embolus
☐Arrhythmia	☐Gout	☐Kidney disorder	☐Reflux
☐Asthma	☐Heart attack	☐Low acting thyroid	☐Rheumatoid arthritis
☐Bleeding problems	☐Heart failure (CHF)	☐Open wounds / Ulcers	☐Seizures
☐Blood clots (DVT)	☐Hepatitis	☐Osteoarthritis	☐Stomach ulcers
☐Cancer	☐High blood pressure	☐Osteoporosis	☐Stroke
☐Coronary heart disease	☐High cholesterol	☐Peripheral vascular disease	Other:_______________
☐Depression	☐HIV/AIDS	☐Pneumonia	____________________

FAMILY HISTORY (CHECK if any of your family have a history of any of the following)

☐ Diabetes	☐ Abnormal bleeding
☐ Heart disease (Heart attack)	☐ Rheumatoid arthritis (Inflammatory arthritis)
☐ Cancer Type:	☐ Anesthesia complications

SOCIAL HISTORY

Do you smoke tobacco? ☐No ☐Yes ☐Past # packs per day _______ # of years _________

Do you use any other nicotine product (patch, vape, chew…)? ☐No ☐Yes ☐Past

Do you drink alcohol? ☐No ☐Yes How many drinks per week?__ **History of substance abuse?** ☐No ☐Yes

List any recreational activities / sports you are involved in: ______________________________

With whom do you live __________

Conservative Treatment prior to Office Visit today			
	Successful (Yes / No)	Did you experience temporary relief?	Comments (Last Visit)
Bed Rest			
Collar / Brace			
Analgesics / NSAIDs			
Physical Therapy			
Chiropractic Therapy Name of Chiropractor: ____________________			
Pain Management Name of Dr.____________			
Injections (Epidural / facet)			

SUN ORTHOPAEDIC & SPINE CARE

REVIEW of SYSTEMS (Have you had any of the following in the past year?)

General	Weight loss or gain	Fatigue	Fever or chills	Weakness	Trouble sleeping	Change in appetite
Skin	Rashes	Lumps	Itching	Dryness	Color changes	Hair and nail changes
Head/Neck	Head injury	Headache	Neck lumps	Neck pain	Neck stiffness	Swollen glands
Ears	Decreased hearing	Ringing in ears (tinnitus)	Earache	Drainage		
Eyes	Glaucoma	Cataracts	Flashing lights	Specks / Floaters		
Nose	Stuffiness	Discharge	Itching	Hay fever	Nosebleeds	Sinus pain
Throat	Sore throat	Hoarseness	Mouth sores	Dentures	Sore tongue	Dry mouth
Cardio-vascular	Chest pain	Leg edema (swelling)	Palpitations	Loss of consciousness		
Gastro-Intestinal	Abdominal pain	Nausea / Vomiting	Diarrhea / Constipation	Bright red blood per rectum	Dark, black tarry stool	
Endocrine	Diabetes	Hyperthyroid	Hypothyroid	Sweating		
Respiratory	Cough (dry or wet, productive)	Sputum (color and amount)________	Coughing up blood	Shortness of breath	Wheezing	Painful breathing
Neuro	Numbness / Tingling	Bowel / Bladder Incontinence	Seizures	Groin Numbness	Tremors	
Musculoskeletal	Hip pain	Knee pain	Shoulder pain	Back pain	Joint pain	

Patient Name ____________________ **Patient Signature** ______________________ **Date**_______________

Reviewed by ____ **Date**_______________