Scott R. Devanny, MD, FAAOS
Robert S. Cummings, Jr., MD, FAAOS
David C. Molind, PA-C, MHP, PT

Patient Information

Last Name: ______________________________ First Name: _____________________________ M: _____

Address: _________________________________ City: ___________________ State: _____ Zip: _________

Home Phone: ______________________ Work: ________________________ Cell: _____________________

Date of Birth: _________________ Age: _________ E-Mail: ____

Gender: F M (circle one) Marital Status: Single Married Other (circle one)

Primary Care Physician: ____________________________________ Phone: ___________________________

Address: _________________________________ City: ____________________ State: _____ Zip: _________

___ Mark if same as PCP

Referring Physician: _______________________________________ Phone: ___________________________

Address: _________________________________ City: ____________________ State: _____ Zip: _________

Pharmacy: __________________________ City/Location: _____________________ Phone: ______________

Employer: ____________________________________ Occupation: __________________________________

Address: _________________________________ City: ____________________ State: _____ Zip: _________

If not employed, are you a full time student? Y N

We would like to scan your insurance card at your first visit so please bring it with you to the appointment.

Please provide insurance information even if this is work or personal injury related

Health Insurance Info - Policy Holder is: Self Spouse Parent Other: ________________ (circle one)

Policy Holder Name: ___________________________ DOB: __________________ Group: _____________

Can skip to Emergency Contact if you provided insurance card(s) to scan

Primary Ins. Company Name: _______________________ Policy Number: _________________________

Secondary Ins. Company Name: _____________________ Policy Number: _________________________

Emergency Contact:

Name: __________________________________ Phone: __________________ Relationship: _____________

Parent or Guardian - Please complete this section if the patient is a minor or full time student:

Last Name: _____________________________ First Name: _________________________ Initial: ____

Address: (skip if same)________________________ City: ___________________ State: _____ Zip: _________

Relationship to patient: Father Mother Guardian Other: ____________________

Initials ____ Date of Birth: ____________ - required on each page to identify document

If this is not related to an injury at work or an auto accident please review statements below and sign the bottom of this page.

Is this injury the result of a WORK or AUTO ACCIDENT?. Y N

If yes, please complete the following:

Social Security Number: ______________________________ (needed for work comp claims)

Injury date and time: ______________________________

What body part(s) was/were injured?: ______________________________

If work related, did the injury happen at your current employer? Y N If no, where were you employed?

____

Claim #: ______________________ Insurance Carrier: ______________________

Case/Claim Manager: ______________________ Phone: ______________ Fax: __________

Claims Address: ______________________________

By signing this sheet I agree with the following statements:

*** I have provided accurate demographic and insurance/billing information.**

*** I understand that it is my responsibility to contact Quality Orthopaedic Care if I move, my insurance coverage changes, or if there are any changes to my demographic information provided with this packet.**

*** I authorize Dartmouth-Hitchcock to: bill my insurance company, and if necessary, release my health information to the insurance company to process my medical claim.**

*** I request that my insurance company make payment directly to Dartmouth-Hitchcock for the services they provide.**

Patient/Guardian Signature: ______________________________ **Date:** ______________

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Patient History and Physical Form

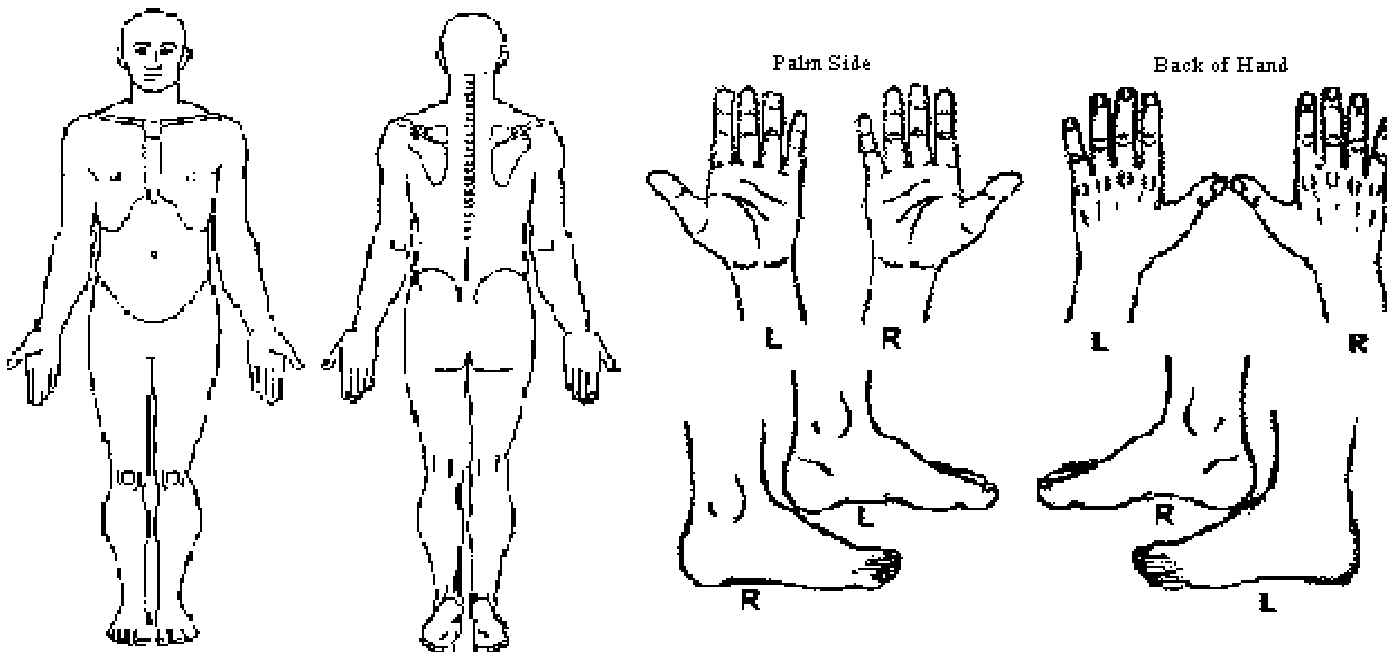
Patient Name: ________________________________ **Date of Birth:** _______________________

What is the reason for your visit/what is the chief complaint?_____________________________

____

What caused the problem? ____

Please mark on the diagram where you are having the problem:



How long have you had this problem? ________ days weeks months years (circle one)

Please mark the symptoms that apply:

◇ **Pain** ◇ **Swelling** ◇ **Bruising** ◇ **Tingling** ◇ **Numbness** ◇ **Laceration/Bleeding** ◇ **Unstable/Weak**

◇ **Locking** ◇ **Popping** ◇ **Grinding** ◇ **Catching** ◇ **Other:**____

What is the severity of the symptoms? (1-10 rating, 10 is the most severe): _________

Past Treatment for this problem:

◇ **Emergency Room** ◇ **Primary Care Doctor** ◇ **Physical Therapy** ◇ **Occupational Therapy** ◇ **Surgery**

◇ **Icing** ◇ **Heat** ◇ **Brace or Sling** ◇ **Other:** ____

◇ **Medications:** ____

What has helped reduce the symptoms?: ____

____

Patient History and Physical Form (cont)

Initials _____ Date of Birth: ____________ - required on each page to identify document

Current and Past Medical Problems:

	Circle One		Describe all yes responses
Eyes	Yes	No	____________________
Ears Nose Throat	Yes	No	____________________
Lungs, Breathing	Yes	No	____________________
Digestion	Yes	No	____________________
Bowel Problems	Yes	No	____________________
Bladder Problem	Yes	No	____________________
Diabetes	Yes	No	If yes, insulin dependent?____________________
High Blood Pressure	Yes	No	____________________
Bleeding Problem	Yes	No	____________________
Balance Problems	Yes	No	____________________
Numbness/Tingling	Yes	No	____________________
Blackout/Fainting	Yes	No	____________________
Psychological Problems	Yes	No	____________________
AIDS	Yes	No	____________________
Cancer (provide type)	Yes	No	____________________
Arthritis	Yes	No	____________________
Polio	Yes	No	____________________
Tuberculosis (TB)	Yes	No	____________________
Epilepsy	Yes	No	____________________
Others not provided	Yes	No	____________________

Are you allergic to Latex? Y N

Are you allergic to Penicillin or any Medications? Y N

Allergies – medication or other – type of reaction:

____________________ ____________________

____________________ ____________________

Past injuries, hospitalizations and surgeries: (Please start with most recent)

Year	Injury\Illness\Surgery	Physician\Hospital
______	____________________	____________________
______	____________________	____________________
______	____________________	____________________
______	____________________	____________________

Current medication: If you have your "meds list" with you please provide to reception to scan.

Medication	Reason for med	Dosage
____________	____________	____________________
____________	____________	____________________
____________	____________	____________________
____________	____________	____________________

Have you ever had an EKG? Y N **If yes, when and why:** ____________________

Have you ever had difficulties with anesthesia? Y N If yes, explain: ____________________

____

Patient History and Physical Form (cont)

Initials _____ Date of Birth: ____________ - **required on each page to identify document**

Have you been treated recently with antibiotics? Y N If yes, for what: ___________________________
(recently = within the last 3-6 months)

Is there a family history of Malignant Hyperthermia? Y N Unknown
(Condition triggered by exposure to anesthesia medications)

Have you ever had Methicillin resistant Staph Aureus? Y N Unknown
(Staph/Bacterial infection resistant to antibiotic methicillin)

Have you ever had Vancomycin resistant Enterococcus? Y N Unknown
(Bacterial infection resistant to antibiotic vancomycin)

Family History: (Please list your immediate family members and their health status)

	Living	Age	Known Medical Conditions or Cause of Death
Mother	Y N	_____	____________________
Father	Y N	_____	____________________
Brother/Sister	Y N	_____	____________________
Brother/Sister	Y N	_____	____________________
Brother/Sister	Y N	_____	____________________
Brother/Sister	Y N	_____	____________________
Father's Parents	Y N	_____	____________________
Mother's Parents	Y N	_____	____________________

What is your height?: ______/______ ft./in **Approximate Weight**: _________ lbs.

Which is your dominant hand? Right Left **Do you smoke?** Y N **Did you smoke?** Y N

Do you drink alcohol? Y N If yes, amount ___________ per day week month (circle one)

How often do you exercise? ________ per week month **What activities?**

____

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Past Workers' Comp Injury:

Have you ever been injured in the workplace? Y N **Did you seek treatment?** Y N

What was the injury? ___________________________________ **When:** ___________________________

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Is there any other information you would like to provide or are there any questions you would like answered regarding your chief complaint?

____

____

Patient/Guardian Signature: ____________________________________ **Date:** __________________

Please complete and bring with you to your first appointment.