Regional Physicians Orthopaedics

Mark Rowley, MD   David Thompson, MD   Richard Avioli, MD
Rebecca Cono PA-C   Mark Banks PA-C   David Chester PA-C

Date________________________________ **Primary Care Physician**____

Referred By who: ____

Last Name   First Name   Middle Name   Social Security #

____

Sex (circle one)   Date of Birth   Marital Status (circle one)

M   F   /   /   S   M   D   W

____

Name of Parent or Guardian (if under 18)   SSN of Parent or Guardian (if under 18)

____

Home Street Address or PO Box Apt#   City   State   Zip Code

____

Home Phone #   Work Phone #   **Mobile #**

(   )   (   )

____

Name of Employer   Employer Street Address or P.O. Box

____ City

State   Zip Code   Employer Phone # (if different from above)

____

Who would you liked contacted in case of an Emergency __________________________ Phone #_____________

How did you find out about us? Please Circle One

YMCA Youth   High Point Little League   High Point Hospital   Yellow Pages   Friend _________   Newspaper Ad   MedCentral

Joint Seminar   Radio

WORKMAN'S COMPENSATION: YES   NO   Date of injury__________________

Claim Number: ____ Claim Address: __________________

Primary Insurance Company Name: *PLEASE GIVE CARD TO FRONT DESK*   **CO-PAY $** _____________

____ ID#__________________________________

Policy Holder Name	Policy Holder Date of Birth	Group#
	/ /	

I hereby authorize Regional Physicians Orthopedics to apply for benefits on my behalf for covered services rendered to me. I request payment from my insurance, if any, to be made directly to Regional Physicians Orthopedics unless otherwise indicated on the claim form. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of information, medical and other, necessary to facilitate process of claims.

The Undersigned Has Read and Understands the Above Terms and Conditions

____

Signature of Responsible Party   Date   Witness   Date

Intake Form

Regional Physicians Orthopaedics

Patient Name ____**DOB**______________________

Primary Care Physician: ____

Who referred you? ____

Pharmacy: ________________________________ **Pharmacy #:** __________________________

Current Active Problems:
Reason for this visit: ____

Main problem you wish to discuss today: ____

Past medical history: None______
Mark/Circle **ALL** if you have ever experienced any of the following symptoms

Y N Asthma
Y N Bleeding Disorder {*Which type*}_______________
Y N Blood Clots
Y N COPD
Y N Depression
Y N Diabetes
Y N Elevated Cholesterol {*Hypercholesterolemia* }
Y N Fainting Spells
Y N Heart Disease/Heart Attack
Y N High Blood Pressure {*Hypertension* }
Y N HIV/AIDS
Y N Hepatitis
Y N Kidney Disease
Y N Liver Disease
Y N Respiratory Problems
Y N Seizures Disorders
Y N Stroke
Y N Thyroid Problems
Y N Staph Infection

List all other medical problems that are not listed above:
____
____

Past Surgical History with dates or hospitalizations - *Ask for more sheets if you need them*
____
____

No past Surgeries (X) ______

List any ongoing therapy (PT, Chiropractor, massage, acupuncture etc)
____
____

Social History:
Adults: single __ married__ divorced__ widowed__
Do You Smoke or use other Tobacco products Y___ N ___ Alcohol Use_________
Drug use: marijuana/cocaine/narcotics Y___ N____ are you or have you ever been under treatment for alcohol or drug dependence? Y ___ N___ Support person_________________________________
History of IV Drug Use? _________________
Sports or extracurricular activities: ____

TURN SHEET OVER

Family History: None_____
Please Mark/Circle **All**. Family includes your parents, children, siblings, aunts and uncles related by blood

Y N Asthma
Y N Bleeding Disorder{*Which type*}_______________
Y N Blood Clots
Y N COPD
Y N Depression
Y N Diabetes
Y N Elevated Cholesterol {*Hypercholesterolemia* }
Y N Fainting Spells
Y N Heart Disease/Heart Attack
circle

Y N High Blood Pressure {*Hypertension* }
Y N HIV/AIDS
Y N Hepatitis
Y N Kidney Disease
Y N Liver Disease
Y N Respiratory Problems
Y N Seizures Disorders
Y N Stroke
Y N Thyroid Problems

Y N Cancer- If yes what type? ________________________________
List other medical problems that are in your family that are not listed above:
____

Allergies: None______
Are you allergic to any medications, foods, bees, latex or contrast dye?_________
If so, what?____

Medications: None_____
List all medications including occasional, Herbal, vitamins and over the counter.
____
____
____
____
____
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____
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____
____

Patient Sign and Date

____