# Merrimack Valley Orthopaedic Associates

**Name**:_____**Date**:_____

**Age**: _____**DOB:** _____**Occupation**:_____ **Right / Left handed**

**Primary Care Physician**:_____

**Primary reason for this visit**:_____

**How did the injury occur**:_____

**Date of your injury**:_____ **Is this a work related injury**? ____ **Yes** ____ **No**

**Ethnicity**: ___Decline to State ___Hispanic or Latino ___Not Hispanic or Latino

**Race**: ___American Indian or Alaskan Native ___Asian ___Black or African American ___Native Hawaiian or other Pacific Islander ___Some other Race ___White ___Decline to State

**Preferred Language**: ___English ___Spanish

## History of Present Illness:

Where is the pain located?_____

Which side? ___**Left** ___**Right**

Describe your pain ___**Sharp** ___**Stabbing** ___**Shooting** ___**Numbnes (Pins&Needles)** ___**Throbbing** ___**Dull**

Pain is ___**Constant** ___**Intermittent Daily** ___**Intermittent most days** ___**Infrequent**

Most pain ___**Morning** ___**During the day** ___**After standing** ___**Night** ___**With activity**

Scale of 1-10 (**10 being worst**), what is your level of pain? __**1**__**2**__**3**__**4**__**5**__**6**__**7**__**8**__**9**__**10**

Have you been seen at a Hospital or another Physician for this problem? _____

Have you had any diagnostic testing? ___**X-ray** ___**MRI** ___**EMG** ___**Labs** ___**CT/Bone Scan**

Have you had any surgery where the pain is located? If yes, please explain:_____

Do you have weakness or numbness associated with your pain? ___**Yes** ___ **No**

Have you tried NSAID medication like Aspirin, Ibuprofen, Aleve, Naprosyn? _____

Have you done any physical therapy, worn braces, splints, etc.?_____

**Past Medical History: Please circle what applies**

| | | |
|---|---|---|
| *High Blood Pressure | *Heart Condition | *Congestive Heart Failure |
| *Kidney Disease | *Bladder Disease | *Reproductive Disease |
| *Neuropathy | *Lung Disease/COPD | *Thyroid |
| *Diabetes | *Cancer | *Sleep Apnea |

*Other_____

*Infectious Disease (Hepatitis B, Hepatitis C, HIV, Tuberculosis, MRSA, or Other _____)

**Past Surgical History**:

Neck/Spine Date:_____ Joint Replacement Date:_____

Hand/Upper Extremity Date:_____ Prostate Date:_____

Shoulder Date:_____ Pacemaker Date:_____

Hip/Pelvis Date:_____ Other:_____

**Osteoporosis:**

Are you taking Calcium supplements with Vitamin D? If yes, what are you taking:_____

Menopause, if so please let us know the start date?_____

Did you have a hysterectomy, if yes, please let us know when:_____

Are you on hormone replacement therapy, or any bone enhancing medication:_____

Have you had a bone density scan (DEXA), if so please list dates: _____

**Social History:**

Alcoholic beverages: ___Yes ___No How often: _____ for how long_____

Do you smoke: ___Yes ___No Packs per day/week _____for how long_____

# PHARMACY AND MEDICATION INFORMATION

## Medication Allergies:

_____

_____

_____

_____

## Current Medications and Dosages:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to Latex? ____ Yes ____ No

Are you allergic to Contrast Dye? ____ Yes ____ No

Preferred Pharmacy: _____

& Phone Number: _____

Patient Name and DOB: _____

Date: _____

Acct#: _____ Date: _____

Patient: _____ Date of Injury: _____

Address: _____ Employer: _____

_____ Address: _____

Home Telephone: _____ _____

Cell Phone: _____ Business Telephone: _____

Age: _____ Date of Birth: _____/_____/_____ Male: _____ Female: _____

Marital Status: S _____ M_____ W_____ D_____ Social Security #: _____

Primary Care Physician: _____ Office Telephone: _____

Contact Person _____ Telephone _____

| MEDICAL INSURANCE | CERTIFICATE NUMBER | SUBSCRIBER | RELATIONSHIP |
|---|---|---|---|
| MEDICARE | | | |
| MEDEX | | | |
| BLUE CROSS/BLUE SHIELD | | | |
| HMO: Name:_____ | | | |
| MASS HEALTH | | | |
| OTHER HEALTH INSURANCE: _____ | | | |
| ADDRESS OF INSURANCE: _____ | | | |

## WORKER'S COMPENSATION / AUTOMOBILE ACCIDENT

Insurance Carrier: _____

Address: _____ Tel #: _____

Claim/File #: _____ Date of Injury: _____

## EXTENDED AUTHORIZATION AND CONSENT

I request that payments of medical benefits be made directly to the physician on any unpaid bills for services rendered to me on or after_____.

I further authorize the release of any medical information necessary to process this or related claims. I also request payment of government benefits to the party who accepts assignment. I permit a copy of this authorization to be used in place of the original.

Signed: _____ Date: _____

O'CONNOR ASSOCIATES

# PLEASE READ – YOUR SIGNATURE IS REQUIRED

VERY IMPORTANT INFORMATION REGARDING YOUR
**INSURANCE AND PRIVACY PRACTICES POLICYIES AND PROCEDUES.**

At each office visit we require your referral and insurance information. This is for your protection. **Without a referral from your insurer, you are responsible for services and/or diagnostic tests. Any non-covered services are your responsibility.**

It is **your** responsibility to provide us with the correct insurance information at the time of service. If there is a problem with your claim, and we do not have a copy of your current insurance card, the balance will become **your** responsibility.

Co-payments are due at the time of service. Any co-payments not paid at this time will incur a $10.00 service charge.

If you **no-show** your scheduled appointment, you may **or** may not be charged a $35.00 no-show fee, at providers discretion.

If this visit is related to an automobile accident, referrals from your health insurance and co-pays if applicable **are still required**.

Thank you,

Merrimack Valley Orthopaedic Associates, LLC.

**Your signature below indicates that you have reviewed a brochure of HIPPA (Health Insurance Probability and Accountability Act of 1996) and have read and understand all of the about information.**

Printed Name: _____DOB_____

Signature: _____Date_____

***If you would like a brochure, please ask one of the receptionists up front.***