For office use only:
Acct#:

DR'S JUGAN, CURCIONE, SWEITZER & HONG

PATIENT INFORMATION

Last Name:		**First Name:**	**Middle Initial:**
*Date of Birth:	Age:	*Sex: (please circle) **Male or Female**	Social Security # (OPTIONAL UNLESS VA)
Mailing Address:	City:	State:	Zip Code
Home Phone:	Cell Phone:	**Marital Status:** (Please circle) MARRIED, SINGLE, DIVORCED, WIDOWED, OTHER;___________	
***Race:** (please circle) WHITE / BLACK /ASIAN / OTHER	***Ethnicity:** (please circle) LATINO / NON LATINO / OTHER	***Preferred Language:**	
E-Mail Address:			
Spouse's Name:	Spouse's Cell phone:	Spouse's Work Phone:	
Your Employer:	Your Occupation/Title:	Work Phone w/ Extension:	
Northern or Other Address: *(if different from mailing)*	City:	State:	Zip Code:

IN CASE OF EMERGENCY

Name of Emergency Contact:	Relationship:	Home Phone:	Work or Cell#

PHARMACY INFORMATION

Pharmacy Name:	Telephone/Location:

PHYSICIAN INFORMATION

Primary Care Physician Name:	Phone #	Which office location:	Did They Refer you?
Cardiologist Physician's Name:	Phone #:	Which office location:	Last EKG?
Pain Management Physician:	Phone #	Which office location:	

***The Items with a * above are required for Electronic Medical Records Meaningful Use Guidelines Required by the US Government.**

CHIEF COMPLAINT

Why are you seeing the doctor today?

BODY PART / RIGHT or LEFT: ____

How & when did the injury/symptoms start? ____

Is this injury due to an Auto accident? **Yes or No** (please describe): ____

____

Is this injury due to a work injury? **Yes or No** (please describe): ____

____

Is this injury from a fall? **Yes or No** (please describe including where): ____

Have you been treated anywhere else for this injury/body part? (other physician, ER, walk-in, Chiropractic, etc.) **Yes or No**

If yes, where? ____

What treatment did they give you? (Splint, meds, injections):

____

Did you have X-rays, MRI, CT, EMG/NCV or other studies done? ____

Where were they done?____

Did you bring these films or reports? **Yes or No**

SMOKING / TABACCO / ALCOHOL HISTORY

Never Smoked:________ Former Smoker: _______ When did you Quit? ____________

Do you use electric cigarettes / vape? ________

Current smoker: _______ If yes, Cigarettes, Pipe, Cigars or Oral e.g.: chew or dip? How many / much per day?_________

Do you drink alcohol? ______________ If yes, how much do you drink weekly? ____

SOCIAL HISTORY

Height: ________________**Weight**: ________________ Are you Right / Left OR Ambidextrous Handed? _______________________

Who do you live with? Spouse, Self, Family, Friends or Other (explain): ____

What is your work status? Full-time/Part-time/Student/Housewife/Retired/Medically Disabled What is your occupation? _____________________

If you are medically disabled, was it due to this injury or something else?
Please describe:____

ARE YOU UNDER THE CARE OR TREATING WITH A PAIN MANAGEMENT PHYSICIAN? YES OR NO
IF YES: Physician name: ___________________________________Phone: ____

MEDICATIONS

PLEASE LIST ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS (INCLUDING *VITAMINS AND HERBAL SUPPLEMENTS*)

____
____
____

ALLERGIES

Do you have any allergies to MEDICATION(s)? (CIRCLE ONE) **Yes or No**

WHAT MEDICATION(S) ARE YOU ALLERGIC TO? ____

____

What type of reaction did you have? (Please explain rash, anaphylaxis etc.):

Do you have a metal allergy? Yes or No explain: ____

Do you have any food allergies? Yes or No explain: ____

Do you have a LATEX allergy? Yes or No explain: ____

Do you have an allergy to eggs? Yes or No explain: ____

AUTHORIZTION FOR TREATMENT AND INSURANCE

I hereby authorize treatment by Ortho Kagan, Orthopedic and Neurospine Institute as deemed reasonable and necessary by the physician at the time of my visit.

X ____ ____
SIGNATURE DATE

I,____ hereby assign all medical and/or surgical benefits to which I am entitled;
PLEASE PRINT NAME

to Ortho Kagan, Orthopedic and Neurospine Institute. A copy or fax of this assignment is valid as the original.

X ____ ____
SIGNATURE DATE

PERSONAL SURGICAL HISTORY

PLEASE CIRCLE ALL THAT APPLY

PLASTIC SURGERY

FACE LIFT, EYELIDS, BREAST AUMENTATION (IMPLANTS), BREAST REDUCTION, TUMMY TUCK

OTHER OR NOT LISTED:____

OB / GYN SURGERY

C-SECTION, HYSTERECTOMY (PARTIAL OR FULL), OVARY REMOVAL, CYST(s) REMOVED, FIBROIDS, URINIARY BLADDER LIFT, TUBAL LIGATION

OTHER OR NOT LISTED:____

HEART / CARDIAC SURGERY

BYPASS how many? ____________________ STENT(S) how many?_________________ PACEMAKER, VALVE REPLACEMENT

OTHER OR NOT LISTED:____

EAR / NOSE /THROAT SURGERY

CATARACTS, LASIX ETC, TONSILLECTOMY, ADENOIDS,THYROID, PARATHYROID, EARS (TUBES ETC), SINUSES, ESOPHAGEAL DILATION

OTHER OR NOT LISTED:____

VASCULAR SURGERY

ABDOMINAL AORITC ANEURYSM (AAA), CAROTID, VEIN STRIPPING, VARICOSE VIENS, SPIDER VIENS,
STENTS WHERE WERE THEY PLACED: (ARM / LEG) ______________ OTHER OR NOT LISTED:____

SPINE SURGERY

CERVICAL:

THORACIC/DORSAL:

LUMBAR:

GASTRO / INTESTINAL / GENERAL SURGERY

HEMORRHOIDECTOMY, BOWEL RESECTION, COLONOSCOPY, COLOSTOMY, ILLEOSTOMY, APPENDIX, GALL BLADDER, GASTRIC BYPASS, HERNIA REPAIR (Inguinal / hiatal)
OTHER OR NOT LISTED:____

MEN: varicocele, vasectomy, prostate biopsy, prostatectomy

URINARY / KIDNEY SURGERY

REMOVAL OF KIDNEY STONES, KIDNEY REMOVAL (RIGHT OR LEFT), KIDNEY TRANSPLANT

OTHER OR NOT LISTED:____

CANCER SURGERY

please list surgery performed below

PLEASE LIST:
____

ORTHOPEDIC SURGERIES

BODY PART	WHAT TYPE OF SURGERY & WHICH SIDE				DATE	SURGEON
SHOULDER	RT		LT			
ARM/ELBOW	RT		LT			
WRIST	RT		LT			
HAND	RT		LT			
HIP	RT		LT			
KNEE	RT		LT			
ANKLE	RT		LT			
FOOT	RT		LT			

Medical History

Current and Past

(PLEASE CIRCLE ALL THAT APPLY)

******IF YOU HAVE NO MEDICAL CONDITIONS, PLEASE CIRCLE NONE **********

NONE	**GENERAL**	Anemia, Alcoholism, Allergies, Anxiety, Bipolar disorder, Bleeding disorder, Blood transfusion, Cataracts, Vertigo, Chicken pox, Deafness, Depression, Drug abuse, Eczema/psoriasis, Glaucoma, Hay fever, HIV/AIDS, Macular Degeneration Mumps/Measles, Lymphoma, Legally blind, Neurofibromatosis, Rashes/Hives, Rubella, Suicide attempt, Tinnitus (*ringing in ear),* Torn retina, Sickle Cell Disease Other: ____
NONE	**BRAIN NEURO**	Stroke, TIA, Seizures, Alzheimer's, Memory difficulty, Headaches, Migraines, Aneurysm, Benign tumors, Tremors, Parkinson's, Dizziness, Brain, Tingling: *Where?* (Hands/Feet) _______________ Other or not listed:______________________________________
NONE	**CARDIO VASCULAR**	High blood pressure/HTN, Heart attack, Chest pain, Phlebitis, Aneurysm, Blood clot / DVT, Excessive bleeding, Easily bruise, Peripheral vascular disease, Angina, Irregular heartbeat, Atrial fibrillation, Aortic valve disease, Mitral valve prolapsed, Abdominal aortic aneurysm, Palpitations, High Cholesterol. Other or not listed: ____
NONE	**GI/LIVER**	Ulcer, GERD/reflux, Heartburn, Indigestion, IBS, Crohn's disease, Colitis, Hepatitis A, B or C, Pancreatitis, Diverticulitis, Cirrhosis, Liver Disease, Gall bladder, Gall Stones, Appendix, Polyps, Hemorrhoids, Abdominal pain, Nausea, Vomiting, Diarrhea. Other or not listed: ____
MUSCULAR SKELETAL (Why you are today..)		Arthritis, Rheumatoid arthritis, Osteoarthritis, Fibromyalgia, Gout, Scoliosis, Osteoporosis, Osteopenia, Bone pain Sprains, Fractures, Tendonitis, Muscle Pain, Joint Pain. Other or not listed: ____
NONE	**RESPIRATORY LUNG**	Asthma, Bronchitis, COPD, Emphysema, Pneumonia, Pulmonary Embolus (PE), SOB, Wheezing, Cough, Sleep Apnea. Other or not listed: ____
NONE	**URINARY RENAL**	Kidney failure (dialysis), Transplant, Stones, UTI /urinary tract infection, Urinate frequently, Burning with urination, Difficulty with urination, Enlarged prostate, Erectile dysfunction, Sexually transmitted disease, Infertility. Other or not listed:____
NONE	**ENDOCRINE**	Thyroid: *High or low* Diabetes: *Type 1 or 2 Diet controlled / Medication controlled / Insulin dependent* Pituitary disorder, Hypoglycemia, Cushing's disease, Hashimoto's, Parathyroid Other or not listed:____
NONE	**CANCERS**	Breast Cancer/ Cervical / Ovarian / Prostate / Colon / Stomach / Colon / Liver / Pancreatic / Throat / Esophagus / Leukemia Skin cancer (where was it removed from and type):____ Bone cancer? ____________________________ Other or not listed: ____________________________________

FAMILY HISTORY (PLEASE MARK ALL THAT APPLY)

	MOTHER	FATHER	SISTER	BROTHER	GRANDPARENTS	OTHER PLEASE SPECIFY RELATION
CANCER						
DIABETES						
EPILEPSY						
HEART ATTACK						
HTN/ BLOOD PRESSURE						
STROKE						
OSTEOPOROSIS						
UNKNOWN OR ADOPTED						

Jugan, Curcione, Sudderth, Sweitzer & Hong

Patient's Acknowledgment of Receipt of Medical Information Privacy Notice

I hereby acknowledge that I received the Ortho Kagan Medical Information Privacy Notice for my review prior to receiving services through the office of Ortho Kagan.

____
Signature of Patient or Patient's Representative

____
Printed Name of Patient or Patient's Representative

____
Relationship of Patient's Representative

____
Date

INSURANCE / HIPAA INFORMATION

(PLEASE PRESENT YOUR CARD AND DRIVERS LICENSE FOR SCANNING)

Is it okay to leave a detailed message on your voicemail/answering machine? ___________________________

Beside yourself, with whom is it okay to discuss your medical care, release medical information and prescriptions on your behalf?

Name: ____ Relationship:___________________________

Name: ____ Relationship:___________________________

Name: ____ Relationship:___________________________

Name: ____ Relationship:___________________________