North Point Orthopaedics

New Patient Intake

Date: _____

Patient Name _____ Birth Date _____ Age _____

ALLERGY HISTORY

Do you have any allergies to medications? ❒ No ❒ Yes. **Please list:** _____
Do you have a latex allergy? ❒ No ❒ Yes _____
Food or Environmental? ❒ No ❒ Yes _____

SOCIAL HISTORY

Do you smoke? ❒ No ❒ Yes. I smoke _____ packs per day
❒ I have smoked in the past, but I quit _____ months / years ago

Do you drink alcoholic beverages? ❒ No ❒ Yes. I drink ____ beverages per day / week. What type?
❒ I have a history of drinking, but do not drink any longer

MEDICAL HISTORY

Place a check in the box if you have ever had any of the following:

❒ Cancer	❒ Neurologic Disease	❒ Kidney Disease	❒ Stomach Ulcer
❒ Aids / HIV	❒ Autoimmune Disorder	❒ Blood Transfusion/S	❒ Major Infection
❒ Gout	❒ High Blood Pressure	❒ Thyroid Disease	❒ Osteoporosis
❒ Strokes	❒ Lung Disease	❒ Rheumatoid Arthritis	❒ _____
❒ Diabetes	❒ Liver Disease/Hepatitis	❒ Anxiety / Depression	❒ _____
❒ Blood Clots	❒ Heart Disease	❒ Bleeding Disorder	❒ _____

Have you ever had a reaction to anesthesia? ❒ Yes. Please describe_____
❒ No

Surgical History

Type of Surgery	Date	Have You Had?	Date of Last exam or n/a
		Mammogram	_____ or ❒ n/a
		Colorectal cancer screen	_____ or ❒ n/a
		Glaucoma screen	_____ or ❒ n/a
		Bone Mineral Density test	_____ or ❒ n/a
		Influenza Vaccine	_____ or ❒ n/a
		Cervical Cancer Screening	_____ or ❒ n/a
		Annual Dental Visit	_____ or ❒ n/a

FAMILY HISTORY

Check all that apply:

❒ Diabetes	❒ Hypertension	❒ Cancer	❒ Stroke
❒ Asthma	❒ Heart Attack/Disease	❒ Seizures	❒ Tuberculosis

Your Immediate Family History

	Major Medical Problems
Father	
Mother	
Siblings	
Children	

CURRENT MEDICATIONS/HEALTH STATUS

Primary Care Physician _____ Other Treating Physicians: _____
Cardiologist: _____

Medication/Dose	Prescribed by	Medication/Dose	Prescribed by

Are you currently taking any weight-loss medications? If so, please specify: _____

Preferred Pharmacy: _____ Location/City: _____

Current Height:_____ Current Weight: _____

HIPAA Release of Information

I, _____ DOB: _____/_____/_____
Please Print Name

As required by the privacy regulations created as a result of HIPAA, North Point Orthopedics is dedicated and committed to your health information. In conducting business, North Point Orthopedics will comply with all legal duties and responsibilities that apply with HIPAA. I have been offered a copy of the HIPAA privacy practice and policy.

I have previously read the office policy. I understand that I am responsible for all charges not paid by my insurance company. Should it be necessary for North Point Orthopedics to submit my account to a collection agency or attorney, I understand I will be responsible for any costs of collection services, including reasonable attorney fees.

I understand that this authorization shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, for this date forward until revoked in writing.

Messages regarding office appointments may be left on my (check ALL that apply):

☐ Cell Phone: _____ ☐ Home Phone: _____

☐ Work Phone: _____ ☐ Email: _____

☐ Sent as text to cell phone

Messages regarding information related to my care may be left on my (check ALL that apply):
☐ Cell Phone ☐ Home Phone ☐ Email

Do you give our medical or billing staff permission to discuss your medical/billing information including laboratory findings with family members or other caregivers?
☐ NO ☐ YES – If yes, please provide name(s) and phone number(s) below:

Name: _____ Relationship: _____

Phone #: _____

Name: _____ Relationship: _____

Phone #: _____

I have given the information above freely, and I am not withholding any medical/billing information at this time.

_____ **Date:** _____
Patient Signature

I have reviewed the above information with the patient.

_____ **Date:** _____
Provider Signature