Total Joint Care

PATIENT DEMOGRAPHICS

First Name _____ Last Name _____

Preferred Name _____ SS# _____-_____-_____

Date of Birth _____/_____/_____ Sex ☐ Male ☐ Female

Address _____

City _____ State _____ Zip _____

Email (TJC use only) _____

Home Phone (_____) _____-_____ ☐ May We Leave Message?

Cell Phone (_____) _____-_____ ☐ May We Leave Message?

	Provider Name	Practice Name
Primary Care	_____	_____
Referring Provider	_____	_____

How Did You Hear About Us? ☐ PCP ☐ Other Referring Provider _____

☐ Friend _____ ☐ Other (PT, Internet, etc.): _____

Medical Health Insurance (Please provide us with your insurance cards, so that we can make a copy.**)**

Primary _____ Member ID _____ Group _____

Secondary _____ Member ID _____ Group _____

Subscriber Name & date of birth if different than Patient _____

Billing Address if different than Patient Address _____

Emergency Contact Information

Name _____ Relationship _____ Phone (____) _____-_____

Name _____ Relationship _____ Phone (____) _____-_____

Preferred Pharmacy

Name _____ Address _____ Phone (____) _____-_____

Total Joint Care

HEALTH QUESTIONNAIRE

Name_____ Date of Birth _____/_____/_____

Reason for visit today _____

Primary Care Provider_____

Medical History *(check each box that applies)*

(*Include details and/or health care specialist***)**

- ☐ Diabetes ☐ Type 1 ☐ Type 2
- ☐ Hypertension _____
- ☐ Heart Disease _____
- ☐ Heart Murmur _____
- ☐ Atrial fibrillation _____
- ☐ Pacemaker _____
- ☐ High cholesterol _____
- ☐ Stroke _____
- ☐ Asthma _____
- ☐ COPD _____
- ☐ Kidney problems _____
- ☐ Renal Failure/dialysis _____
- ☐ Liver disease/hepatitis _____
- ☐ Bleeding/Clotting problems _____
- ☐ Vascular disease _____
- ☐ Gout _____
- ☐ Epilepsy _____
- ☐ Cancer (type): _____
- ☐ Infection (type): _____
- ☐ Other: _____
- ☐ Other: _____

Medications/Vitamins/Herbal Supplements

☐ **See List Provided**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____

Medication Allergies ☐ **No Known Allergies**

- ☐ Latex ☐ Iodine/ Shellfish
- ☐ NSAIDS ☐ Penicillin
- ☐ Sulfa ☐ Lidocaine
- ☐ Metals (type): _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Hospitalizations/Surgeries	**Date**	**Surgeon/Facility**
1.		
2.		
3.		
4.		
5.		

Current Height _____ **Current Weight** _____

Social History

Occupation _____ ☐ Retired _____

Marital Status:	☐ Single	☐ Married	☐ Other _____
Do you smoke?	☐ No	☐ Yes	☐ Quit _____
Chew tobacco?	☐ No	☐ Yes	☐ Quit _____
Drink alcoholic beverages?	☐ Never	☐ Seldom	☐ Socially ☐ Daily
Use recreational drugs?	☐ No	☐ Yes	Type: _____

Name_____ Date of Birth _____/_____/_____

Family History

(Please check any that apply and indicate by (number), family member(s) with same medical history)
Mother (1) Father (2) Mother's Parents (3) Father's Parents (4) Siblings (5) Children (6)

☐ Diabetes _____ ☐ Lung Disease _____ ☐ Alcohol_____ ☐ Drug abuse_____
☐ Cancer_____ ☐ Cardiac_____ ☐ Rheumatoid_____ ☐ Other _____

Review of Symptoms (*Please check all that apply*)

Infectious Disease Do you currently have, or have you had in the past, any reportable infectious diseases?

☐ HIV/AIDS ☐ Hepatitis (Type) ___ ☐ Tuberculosis (When?) _____
☐ Skin / Abdominal / Other (When?) _____

General:	☐ **NONE**	☐ Excessive fatigue	☐ Weakness	☐ Fever	☐ Other: ____
Eye Problems:	☐ **NONE**	☐ Glasses	☐ Cataracts	☐ Glaucoma	☐ Other: ____
Ear, Nose, Throat:	☐ **NONE**	☐ Poor swallowing ☐ Allergies	☐ Nose bleeds ☐ Hearing loss	☐ Sore throat ☐ Other: _____	☐ Ear pain
Cardiovascular:	☐ **NONE**	☐ High blood pressure ☐ Heart attack	☐ Chest pain ☐ Vascular problems	☐ Palpitations ☐ Other: _____	☐ Blood clot
Respiratory:	☐ **NONE**	☐ Asthma ☐ Sleep apnea	☐ Shortness of breath ☐ Other: _____	☐ Bronchitis	☐ Pneumonia
Gastrointestinal:	☐ **NONE**	☐ Heartburn ☐ Constipation	☐ Nausea ☐ Gallbladder	☐ Abdomen pain ☐ Other:_____	☐ Reflux/Ulcers
Genitourinary:	☐ **NONE**	☐ Painful urination ☐ Blood in urine	☐ Frequent urination ☐ Other: _____	☐ Prostate	☐ UTIs
Musculoskeletal:	☐ **NONE**	☐ Joint stiffness ☐ Osteoporosis	☐ Muscle cramps Other: _____	☐ Balance	☐ Fibromyalgia
Skin:	☐ **NONE**	☐ Rash/Itch	☐ Hives	☐ Lupus	☐ Other: ____
Neurological/ Psychological:	☐ **NONE**	☐ Headaches ☐ Anxiety ☐ Numbness	☐ Memory loss ☐ Depression ☐ Other: _____	☐ Seizures ☐ Stroke	☐ ADD/ADHD ☐ Tremors
Endocrine:	☐ **NONE**	☐ Weight gain ☐ Gout	☐ Weight loss ☐ Liver problems	☐ Diabetes ☐ Other: _____	☐ Thyroid
Hematologic:	☐ **NONE**	☐ Bruise easy	☐ Prolonged bleeding	☐ Anemia	☐ Other:_____
Reproductive:	☐ **NONE**	☐ Pelvic pain ☐ I am pregnant	☐ Heavy bleeding ☐ I am not pregnant	☐ Cyst Date of Last Period: _____	☐ Other: ____

Please describe significant symptoms, medical problems or personal events not marked above

_____

Signature _____ **Date** ___/____/_____ **Legal Guardian** ☐ **POA** ☐

Total Joint Care

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION & PRIVACY POLICY

I understand that by signing this consent I authorize TJC to use and disclose my protected health information to carry out treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); and obtaining payment from third party payers (e.g. my insurance company).

☐ I authorize release of my medical information from Total Joint Care to my insurance companies to facilitate payment of claims, obtain authorization for advanced imaging, and obtain authorization for surgical procedures.

☐ I have been informed of this practice's policy of complying with HIPAA guidelines and I have been offered a copy of those regulations.

☐ I authorize that the following persons can be contacted and/or informed about my medical treatment. (This typically means family members or friends that help you monitor your health.

Name _____ Relationship _____ Phone (_____) _____-_____

Name _____ Relationship _____ Phone (_____) _____-_____

Name _____ Relationship _____ Phone (_____) _____-_____

☐ I authorize release of my medical information FROM Total Joint Care to referring and referral providers about the assessment, diagnosis, and treatment of my medical conditions in accordance with HIPAA regulations involving 'continuity of care'.

☐ I authorize release of my medical information TO Total Joint Care from providers in accordance with HIPAA regulations involving 'continuity of care'.

☐ Please send office note to any additional providers.

Provider _____ Phone (_____) _____-_____

Provider _____ Phone (_____) _____-_____

Name_____ Signature_____ Date_____/_____/_____