Cumberland Orthopedics

118 Brown Avenue, Suite 103
Crossville, TN 38555
ph 931.484.8861 fax 931.456.1319

Date: _____

PATIENT INFORMATION

Name (Last, First, Middle):			SSN#	Birthdate	Age	Sex
Mailing Address			City, State, Zip			
Home Phone	Cell Phone		Email Address			
Marital Status	Student Status ☐Full-Time ☐Part-Time	Smoker? Yes or No	Veteran (Y/N)?	Ethnicity: Hispanic or Non-Hispanic	Primary Care Physician	
Referring Physician	Referring Physician Contact #	Other Medical Providers				
Race (**Circle Answer**): African American, Alaskan Native, Asian, French, German, Greek, Hawaiian, Hispanic, Indian, Multi-Racial, Native American Indian, Pacific Islander, White					Language	
Emergency Contact Name	Emergency Contact Phone #s Hm:		Cell:			
Employer Name and Address			Work Phone #			

How did you learn about our office? Please circle one. Billboard Ad Direct Mail Hospital Referral Insurance Newspaper Ad Patient Referral Physician Referral Previous Patient Internet Self-Referral Yellow Pages Other:

If patient is a minor, please fill out this portion

Parent or Guardian's Name:	Parent or Guardian's Phone #s Hm:	Wk:	Cell:

RESPONSIBLE PARTY INFORMATION (if different from above)

Name (Last, First Middle	SSN#	Birthdate	Sex
Address	City, State, Zip		
Home Phone / Cell Phone / Work Phone	Relationship to patient		

PRIMARY INSURANCE

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN #	Insured's Insurance ID #	Relationship to patient

SECONDARY INSURANCE (if applicable)

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN#	Insured's Insurance ID #	Relationship to patient

Workers Compensation

Are you here for workers compensation YES____ NO____ Date:

Accident

Auto ☐ Work ☐ Other ☐ Date of Accident:

Do you have any Advanced Directives? (e.g., Living will or Advanced Care Plan) Yes_____ No_____

Do you have a Power of Attorney? Yes_____ No_____

If yes to the above questions please make sure we have a copy for your medical record.

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Medical History and Review of Systems

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Past Medical History: Please check any that apply to you

- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Breast Cancer
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD/Emphysema
- ☐ Heart Disease
- ☐ Depression
- ☐ Diabetes (Type 1)
- ☐ Diabetes (Type 2)
- ☐ GERD (Acid Reflux)
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity
- ☐ Prostate Enlargement
- ☐ Prostate Cancer
- ☐ Radiation Therapy
- ☐ Seizures
- ☐ Stroke
- ☐ Parkinson's Disease
- ☐ Other: _____
- ☐ Other: _____

Past Surgical History: Please check any that apply to you

- ☐ Appendix
- ☐ Breast
  - o Mastectomy (Left / Right)
  - o Lumpectomy (Left / Right)
  - o Implants
- ☐ Colon
  - o Colon Cancer
  - o Diverticulitis
  - o Inflammatory Bowel Disease
- ☐ Gallbladder
- ☐ Heart
  - o Bypass Surgery
  - o Stents (PTCA)
  - o Valve Replacement
  - o Transplant
- ☐ Kidney
  - o Kidney Stones
  - o Kidney Transplant
- ☐ Ovaries
  - o Ovarian Cancer
  - o Ovarian Cyst
  - o Ovary Removal (Left / Right)
  - o Other: _____
- ☐ Prostate
  - o Prostate Cancer
  - o Prostate Biopsy
  - o TURP Procedure
  - o Prostate Removal
- ☐ Skin
  - o Biopsy
  - o Basal Cell Skin Cancer
  - o Squamous Cell Skin Cancer
  - o Melanoma
- ☐ Uterus
  - o Total Hysterectomy
  - o Partial Hysterectomy
- ☐ Other:

_____

_____

_____

_____

Orthopedic Surgical History: Please check and circle any that apply to you

- ☐ Ankle Fracture: *Both* *Left* *Right*
- ☐ Carpal Tunnel Decompression: *Both* *Left* *Right*
- ☐ Cervical Spine Surgery: *Yes* *No*
- ☐ Disc Replacement Surgery: *Yes* *No*
- ☐ Distal Radius: *Both* *Left* *Right*
- ☐ Correction of Femur Fracture: *Both* *Left* *Right*
- ☐ Correction of Tibia Fracture: *Both* *Left* *Right*
- ☐ Joint Replacement - Hip: *Both* *Left* *Right*
- ☐ Joint Replacement – Knee: *Both* *Left* *Right*
- ☐ Joint Replacement – Shoulder: *Both* *Left* *Right*
- ☐ Knee Arthroscopy: *Both* *Left* *Right*
- ☐ Kyphoplasty / Vertebroplasty: *Yes* *No*
- ☐ Lumbar Spine Decompression Surgery: *Yes* *No*
- ☐ Lumbar Spine Fusion Surgery: *Yes* *No*
- ☐ Rotator Cuff Repair: *Yes* *No*

Please complete both sides of form

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Medical History and Review of Systems

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Orthopedic History: Please check any that apply to you

- ☐ Ankylosing Spondylitis
- ☐ Bursitis
- ☐ Dish
- ☐ Distal Radius Fracture
- ☐ Epidural Injection, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Primary Bone Sarcoma
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency

Family History: Please check any that apply to you

	Mother	Father
Deceased	☐	☐
Diabetes	☐	☐
High Blood Pressure	☐	☐
Osteoarthritis	☐	☐
Osteoporosis	☐	☐
Heart Disease	☐	☐
Cancer	☐	☐

Tobacco Usage:

☐ Not a Tobacco User ☐ Current Tobacco User ☐ Former Tobacco User

How many packs/cans/couches a day do you use? _____ Packs/Cans/Pouches per Day

For how many years have you used tobacco? _____ Years

Immunization History:

Have you had your Flu Shot? **YES NO**

When? _____ Provider or Place? _____

*Have you had your **Pneumonia Shot?** (Patients 65 years and older) **YES NO**

When? _____ Provider or Place? _____

☐ I affirm that the information I have given is correct to the best of my knowledge. I understand that my medical records are held in the strictest confidence and that it is my responsibility to inform Cumberland Orthopedics of any changes in my medical status.

_____ _____

Signature Date

Please complete both sides of form

Medication Record

Name: ______________________________ Date: ______________

Allergies:

☐ **NKA** **Date:**

____

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____

____

Problem List

____

____

____

____

____

____

____

Family Doctor: ______________

Pharmacy: ______________

Prescription	Strength	How often					