ORTHOPAEDIC ASSOCIATES
of KENTUCKIANA, P.L.L.C.

3605 Northgate Court, Suite 202, New Albany, Indiana 47150

Dear Patient:

Welcome back. We are honored that you have returned to us for your care, and we are committed to providing you with the best care we can. Our hope is that we form a partnership to keep you as healthy as possible, no matter what your current state of health. We will share our medical expertise with you, and we hope you'll take responsibility for working toward the healthy lifestyle that is so important to your well-being.

You trust us to care for the most important thing you have- your health. At Orthopaedic Associates we are dedicated to providing the best in orthopedic care to people from all walks of life and all ages. We want help you regain the ability to choose your own activities. The team approach to helping you heal from your orthopedic problem is the key to our method. Years of experience with patients who have sports injuries, accidents, fractures, or the effects of aging have allowed us to develop a customized solution to your problem. While many patients are best treated without surgery, rest assured, if surgery is needed, we have the experience to help you be the best you can be. Our extensive experience, particularly in shoulder surgery and knee surgery, is to your benefit.

While we enjoy spending time with you, there are a few housekeeping notes to help decrease the length of time you spend at the office:

1. Bring all of your health insurance cards (we will ask for them at every visit).
2. Have photo identification (current driver's license, employee badge or military identification card) or two forms of alternate identification that includes your name and address (such as utility or phone bills or lease agreement). For minors, acceptable forms of photo identification include a current wallet-sized photo, school identification card, military identification card, or if accompanied by a parent, parent's photo identification.
3. Bring all medications you are currently taking, including vitamins and over the counter medications. If you bring a list, please make sure it is current. This will ensure your medication list is accurate and current with correct dosages and dosing instructions.
4. Please complete the attached forms prior to your arrival.
5. If you are having a problem with your shoulder please wear or bring a tank top and/or sports bra to wear during the examination. If you are having a problem with your hip/knee/foot, please bring a pair of shorts to wear during the examination.

We are pleased to be at your service.

The Team at Orthopaedic Associates

New Problem History

Today's Date:_____

Your Name:_____

Birthdate:_____

Why do you want to see the Doctor?

What were you doing the first time it hurt?_____

Where is the problem?_____

How long has it been bothering you?_____

When does it bother you?_____

_____

On a scale of 1-10 how bad is it?_____

What is the pain like?_____

What makes the problem better?_____

What makes the problem worse?_____

Are other things associated with the problem?_____

_____

Have you had this problem before?_____When?_____

Who treated you then?_____

Have you had any tests done?

Type of Test	When?	Where?	What did it show?

Are you seeing another doctor having any other problems with your health ?

Diagnosis? (Diabetes, Blood Pressure, Heart Attack?)	Are you using medicine?	What is the name of the medicine?	Who is the doctor treating you for this?

Are you using any other medicines? Please include over the counter or natural meds

Medicine Name	Dosage	How Often	When did you start?

Is there anything else the doctor should know?

I have answered the questions truthfully and as best I can

Signature:_____ Date:_____

New Problem Medical History - Please Fill Out Completely

Last Name_____ First name _____ M.I._____

Date of Birth_____ Age _____ Height_____ Weight _____

Do you have, or are you being treated for any of the following, Check all that apply.

❑ High blood pressure	❑Pacemaker	❑Blood clots
❑ Asthma	❑Kidney disease	❑Bleeding problems
❑ Emphysema	❑Stomach/Colon disease	❑Cancer
❑ Diabetes	❑Ulcers	❑Hepatitis
❑ Seizures	❑Stroke	❑HIV/AIDS
❑ Heart disease	❑Neuropathy	❑Other:

Please list all surgeries in the past three years

_____

_____

_____

Please list ALL medicines (including non-prescription/supplements). If you need more room please complete the medication list sheet. I you use no medicines check this box ❑

Medicine	Dosage	How often?	For what condition?

List ALL allergies. ❑ No Allergies. LATEX ALLERGY ❑ Yes ❑ No
If you need more room complete the medication list sheet.

Medicine	Reaction	Medicine	Reaction

Alcohol use ❑ Yes ❑ No Number of drinks:_____ (circle one) day week month

Tobacco use ❑ Yes ❑ No Cigarettes (packs/day) _____

Cigars/Pipe (number/day) _____

Dip/Chew (amount/day) _____

Family History - Check all that apply.

❑ Birth. Defects	❑ Heart disease	❑ Bleeding problems
❑ High blood pressure	❑ Kidney disease	❑ Cancer
❑ Asthma	❑ Stomach/Colon disease	❑ Hepatitis
❑ Emphysema	❑ Ulcers	❑ HIV/AIDS
❑ Diabetes	❑ Stroke	❑ Other:
❑ Seizures	❑ Blood clots	

Work ❑ Employed ❑ Unemployed ❑ Retired ❑ Disabled ❑ Student

Type of work performed_____

Next of kin (not living with you)_____

Address_____ **Phone** _____**Relation**_____

Signature_____ **Date**_____

ORTHOPAEDIC ASSOCIATES
of KENTUCKIANA, P.L.L.C.

3605 Northgate Court, Suite 202, New Albany, Indiana 47150

PATIENT MEDICATIONS and ALLERGIES

Name_____ Date of Birth_____

Today's Date_____

ALLERGIES

Medication	Reaction (What goes wrong when you use the medicine?)

CURRENT MEDICATIONS

Medication	Dosage	How Often?	For What Condition?

Signature:_____ Date _____

ORTHOPAEDIC ASSOCIATES of KENTUCKIANA PLLC

DEMOGRAPHIC INFORMATION

Patient's Name (First, Middle, Last)			
Patient's Address			
City, State		Zip	
Date of Birth	Age	Sex	Soc Sec #
Home Phone	Cell Phone	Work Phone	
Are You: Actively Employed ❑ Retired ❑ Disabled ❑			
Employer			
Employer's Address (Street)			
City, State		Zip	
Occupation (Indicate if Student)			
Nearest Relative/Friend (not in same household)			
Address		Phone	
City, State		Zip	
Referred by		Phone	
Address			
City, State		Zip	
Family Doctor or Pediatrician		Phone	
Address			
City, State		Zip	
Is Spouse Employed ❑ Retired ❑ Disabled❑		Soc. Sec. No.	
Employer		Employer's Phone	
Occupation			
Employer Address (Street)			
City, State		Zip	

Father's Name (First, Middle, Last)		Soc Sec No	
Employer		Employer's Phone	
Occupation			
Employer's Address (Street)			
City, State		Zip	
Mother's Name (First, Middle, Last)		Soc. Sec. No.	
Employer		Employer's Phone	
Occupation			
Employer Address (Street)			
City, State		Zip	
Name of Policyholder		Birth date	
Insurance Address			
City, State		Zip	
Policy Number		Group Number	
SECONDARY INSURANCE			
Name of Policyholder		Birth date	
Insurance Address			
City, State		Zip	
Policy Number		Group Number	
If Accident Related	Work Injury ❑ Yes ❑ No	Automobile Injury ❑ Yes O No	
Date of Accident and Description			

RELEASE INFORMATION: I hereby authorize the release of medical information to my family doctor and/or referring doctor and to insurance carriers concerning my illness and treatment. I hereby request payment of benefits to Orthopaedic Associates of Kentuckiana, PLLC. I understand I am responsible for any amount not covered by insurance.

SIGNATURE PATIENT OR GUARDIAN _____ Date_____