GCH Orthopedic Services

710 North Street, Guthrie Center, Iowa 50115 Phone: (641) 332-3900 Fax: (641) 332-3906

MR # _____

PATIENT INFORMATION

Patient Name_____Gender: __M __F Marital Status:____Birthdate:_____

Address:_____

Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Soc Sec Num: _____

Employer:_____ Work Phone: _____

How were you referred to us?

__Friends/Family __Newspaper __Flyer __Doc Office __ER __Staff __Staff Referral __Other-Who?_____

Primary Physician: _____

Doctor Address City State Zip Phone #

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ Phone #: _____

Claim Address: _____

Street City State Zip Code

Policy Number: _____ Group Name: _____ Group Number:_____ Copay:_____

Policy Holder's Name: _____ Phone #:_____ DOB: _____ SS#: _____

Address: _____ Relationship: _____ Employer: _____

SECONDARY INSURANCE: _____Phone #: _____

Claim Address: _____

Street City State Zip Code

Policy Number: _____ Group Name: _____ Group Number:_____ Copay:_____

Policy Holder's Name: _____ Phone #:_____ DOB: _____ SS#: _____

Address: _____ Relationship: _____ Employer: _____

LEGAL ISSUES

Is this a worker's compensation case? __Yes __No

Do you have an attorney assisting you? __Yes __ No

I authorize GCH as a holder of medical information, to release to my insurance carrier or its intermediaries any information needed for this or future related claims. I acknowledge and understand I am financially responsible for any portion of my bill not covered by the insurance carrier. If not filing to insurance, I will pay $ 170 toward anticipated charges, which may include X-rays or supplies. For work related injuries, my personal insurance will be used in the event worker's compensation denies the claim.

Signature: _____ Date: _____

MR #: _____

CURRENT INJURY/COMPLAINT

What is the problem you are here for today? Describe symptoms: (Example: Swelling, right leg pain, etc)

_____

_____

_____

How would you describe the problem? ___ Improved ___ Worsened

Have you had: __ X-rays If so, when? _____
__ MRI If so, when? _____
__ CT Scan If so, when? _____
__ EMG If so, when? _____
__ Other If so, when? _____

ATHLETIC PARTICIPATION

Were you injured while participating in a sport? __ Yes __ No

If yes: School _____
Sport _____
Coach _____

PATIENT HISTORY

How do you rate your general health? __EXCELLENT __GOOD __FAIR __POOR

Are you allergic to any medications or x-ray dyes?_____

_____

Please list all medications that you are taking:_____

_____

Please list any surgeries you have had and when: _____

_____

Occupation-what kind of work do you do? _____

How many hours per week do you work? _____

Do you exercise regularly? __YES __ NO

Do you smoke? __YES __ NO

How many alcoholic beverages do you consume per week? __ None __ 1-3 __4-12 __13+

Do you use non-prescriptions or mind altering drugs?(Ex: Marijuana) __YES __NO

Do you use performance enhancing drugs? __ YES __NO

Is there anything you have been treated for that we should be aware of?

_____

Is there any family history we should be aware of?(EX: Heart disease, diabetes, cancer)

_____

Signature: _____ Date: _____