MANOOGIAN ORTHOPEDIC CENTER, P.A.

1945 Bay Road • Mount Dora, Florida 32757 • Phone: 352-483-5633 • Fax: 352-483-5070

Date:_____

Demographic Information

First Name M Last Name

Date of Birth Age Race Sex SSN

Street Address

City State Zip Code

Northern Address

Contact Information

Email:

Phone Number:

Marital Status: Married Single Widowed Divorced

Spouse's Name :

Spouse's Date of Birth:

Phone Number:

Primary Insurance: Member ID #:

Secondary Insurance: Member ID #:

Contact in Case of Emergency:

Name (other than spouse):

Relationship: Phone Number:

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Patient Name_____ **Date of Birth** _____ **Sex**_____

Family Physician_____ **Referring Physician**_____

Injury Information

Was your injury the result on an accident:	Yes	No
Are there Attorneys involved in the case:	Yes	No
Will a Lawsuit be filed in this case:	Yes	No

Chief Complaints

Chief Complaints

Location:	Where is your pain?	_____
Radiation:	Which extremities does the pain radiate to?	_____
Quality:	What type of pain are you feeling (Sharp, dull, stabbing)	_____
Duration:	How long have you had pain? Date of Accident (if applicable)	_____
Timing:	When does the pain occur? How long does it last?	_____
Context:	Walking, sitting, sleeping: what makes it worse?	_____
Modifying factors:	What makes it better?	_____
Associated signs and symptoms:	Swelling, redness, fever, etc.	_____

Past Medical History

Past Medical History (Health)

1 _____
2 _____
3 _____
4 _____
5 _____

Past Surgical History (Operations)

1 _____
2 _____
3 _____
4 _____
5 _____

Medications: (Please list)

1 _____
2 _____
3 _____
4 _____
5 _____

Allergies: (Please list)

1 _____
2 _____
3 _____
4 _____
5 _____

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Social History

Social History:

Alcoholic beverages _____ # per day
Tobacco/cigarettes/cigars _____ packs per day for _____ years
Quit what year? _____

Work History

Work History:

My job is: _____

My job requirements are:

_____ Heavy: lifting over 60 pounds and frequently bending and stooping
_____ Medium: Lifting 30 to 50 pounds
_____ Light: Lifting 10 to 20 pounds
_____ Sedentary: sit most of the time – very little lifting
_____ My job has a high stress level – it makes me tense
_____ How long disabled?

Family Medical History

Family Medical History

Mother:

_____ Alive and well
_____ Deceased
Alive and well but suffers with _____
Cause _____
_____ age
_____ age at death _____

Father:

_____ Alive and well
_____ Deceased
Alive and well but suffers with _____
Cause _____
_____ age
_____ age at death _____

I have:

_____ Living brothers/sisters
_____ Deceased brothers/sisters
_____ Cause of death(s) _____

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Members of my family (brothers, sisters, grandparents, aunts and uncles) who suffer with *the following*:

_____ Stroke	_____ High blood pressure
_____ Diabetes	_____ Heart trouble
_____ Arthritis	_____ Lung disease
_____ Cancer (type)	_____ I don't know
_____ Back problems	_____ Other

Review of Systems: Circle all that apply

Constitutional
Weight loss
fatigue
Fever

Eyes
Glasses/contacts
Pain
Double vision
Glaucoma
Cataracts
Inflammation

Ears
Difficultly hearing
Hearing aid
Ringing/buzzing
Infections

Nose/ throat
Sinus trouble
Post nasal drip
Nosebleeds
Trouble swallowing
Sore throats

Gastrointestinal
Heartburn
Nausea/vomiting
Stomach ulcer
Constipation
Diarrhea
Change in BM's
Bloody stool
Gallbladder trouble
Liver problems

Skin
Rashes/sores
Skin cancers
Itching/burning

Musculoskeletal
Joint pain/swelling
Stiffness
Muscle pain
Back pain

Hematologic
Anemia
Easy bruising
Bleeding problem
Enlarged glands

Endocrine
Loss of hair
Change in nals
Heat/cold intolerance

Respiratory
Asthma
Wheezing
Coughing

Cardiovascular
Chest pain
Irregular heartbeat
Low blood pressure
High blood pressure
Shortness of breath
Leg/ankle swelling
Cold fingers/toes
Sweaty fingers/toes

Genitourinary
Painful urination
Urine leakage
Frequent urination
Nighttime urination
Blood in urine
History of kidney stones
Abnormal discharge
History of sexually transmitted disease

Neurological
Fainting
Seizures/epilepsy
Numbness/tingling
Weakness/paralysis
Memory loss
Stroke

Psychiatric
Anxiety
Depression
Drug/alcohol abuse

Other

I certify that I have read the above answers to the questions and duly swear and/or affirm that the answers given are true and correct.

Signature _____ Date_____

MANOOGIAN ORTHOPEDIC CENTER, P.A.
Comprehensive Orthopedic Center
1945 Bay Road • Mount Dora, FL 32757 • Phone (352)483-KNEE (5633) • Fax (352)483-5070

Name: _____ DOB: _____

Primary Care Physician: _____

Cardiologist: _____

Height: _____ Weight: _____

Have you ever been admitted into a nursing home/rehab facility? Yes No

Have you ever tested positive for MRSA? Yes No

Have you had a pneumonia shot? Yes No When? _____

Have you had a flu shot? Yes No When? _____

Do you have a pacemaker? Yes No

***If there are any changes to your insurance, please let the receptionist know.**

Sign: _____ Date: _____

Manoogian Orthopedic Center, P.A.

Medical Information Release Form

(HIPPA Release Form)

Name: _____ Date of Birth: _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

_____ _____

_____ _____

_____ _____

[ ] Information is not to be released to anyone

This **Release of Information** will remain in effect until terminated by me in writing

Message

Please call [ ] my home [ ] my work [ ] my cell number _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time)_____

Signed:_____ Date:_____

Witness: _____ Date:_____

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State:_____ Zip:_____

I hereby authorize you to release records to/from: MANOOGIAN ORTHOPEDIC CENTER.

Name: _____

Address: _____ _____

City: _____ State: _____ Zip: _____

Phone _____ Fax: _____

The specific information I wish to have released is (please include dates of treatment):

_____

_____

In addition to the general authorization to release confidential medical record information, I authorize the release of the records described as the following:

- Communicable disease-related information, including records of testing, diagnosis, or treatment for HIV, HIV-related illness, AIDS, AIDS-related diseases. ☐ YES ☐ NO
- Drug And alcohol treatment. ☐ YES ☐ NO
- Psychological/psychiatric information, including diagnosis and treatment. ☐ YES ☐ NO

The release is at my request for further medical care.

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a ninety (90) day period from the date it is signed.

_____ _____

Signature: (Patient or Legal Representative) Date

Manoogian Orthopedic Center, P.A.

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child (ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone

This **Release of Information** will remain in effect until terminated by me in writing

Messages

Please call [ ] my home [ ] my work [ ] my cell number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a detailed message asking me to return your call

[ ] _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: _____

Witness: _____ Date: _____