HOUSTON Methodist ORTHOPEDICS & SPORTS MEDICINE

Patient Information Form

____ _____-_____-_____ ____________

Patient Name (Last, First, Middle): Social Security #: Sex

____ _____-_____-______ / _____-______-______

Address: Home Phone # Cell Phone #

________________________ ______ __________ ____________________________________

City State Zip Code Occupation:

____/____/______ _____________ ____

Date of Birth: Marital Status Referred By:

____ ______-______-______

Employer Name and Address: Work Phone #:

__________________________________ ____________________ ______-______-_______

Emergency Contact Name: Relationship: Emergency Phone #:

GUARANTOR INFORMATION:

_______________________________________ _____-_____-_______ ____/____/_____

Policy Holder Name: Guarantor SS#: Guarantor DOB:

_______________________________________ _______________ _____ ____________

Address: City State Zip Code

____ _______-_______-______

Employer Name and Address: Employer Phone #:

PRIMARY INSURANCE INFORMATION:

____ ______-______-________

Name of Primary Insurance Carrier: Verification Phone #:

____ ________________________

Subscriber Name and Member ID #: Group #/Policy #:

SECONDARY INSURANCE INFORMATION:

____ ______-______-________

Name of Secondary Insurance Carrier: Verification Phone #:

____ ________________________

Subscriber Name and Member ID #: Group #/Policy #

Payment is required at the time services are rendered. Thank You!

HOUSTON Methodist ORTHOPEDICS & SPORTS MEDICINE

Evan D. Collins, M.D. **Department of Orthopedic Surgery**

Name: ____ **Today's Date:** _________________________________

Date of Birth: _____/_____/______ **E-mail address:** ________________________________

Referring Physician Name: _____________________________ **Referring Physician Phone #:**______________________

Gender: Male / Female **Dominant Hand:** Left / Right **Affected Upper Extremity:** Left / Right

Reason for your visit today: ____

____

____

*****Is this a visit due to a: Personal Injury Automobile Accident Work Related Injury*****

Please circle any symptoms you may have:

Fatigue	Y	N	Muscle or joint pain	Y	N
Weight change	Y	N	Muscle or joint stiffness	Y	N
Skin rashes or sores	Y	N	Muscle or joint swelling	Y	N
Changes to nails	Y	N	Muscle or joint weakness	Y	N
Cough	Y	N	Limited range of motion	Y	N
Nervousness	Y	N	History of arthritis	Y	N
Hot or cold intolerance	Y	N	History of trauma	Y	N
Excess sweating	Y	N	Numbness	Y	N
Easy bruising	Y	N	Tingling	Y	N

Please circle any of the medical conditions you have or had in the past:

Heart Problems	Y	N	High Blood Pressure	Y	N	Cancer	Y	N
Blood Clots	Y	N	Irregular Heart Beat	Y	N	Arthritis	Y	N
Thyroid Problems	Y	N	Diabetes	Y	N	Childhood Diseases	Y	N
Asthma	Y	N	Hepatitis	Y	N	Psychiatric Problems	Y	N
Tuberculosis	Y	N	Peptic Ulcers	Y	N	Bleeding Problems	Y	N
Hiatal Hernia	Y	N	Pneumonia	Y	N	Colitis	Y	N
Kidney Infection	Y	N	Urinary Infection	Y	N	Blood Transfusion	Y	N
Kidney Stones	Y	N	Gallbladder Problems	Y	N	HIV/AIDS	Y	N

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Evan D. Collins, M.D.　　Department of Orthopedic Surgery

Are you pregnant? Yes No **Last menstrual period:** ____________________________________

Do you smoke? Yes No **If so, how much?** ____

Do you drink alcohol? Yes No **If so, how much?** ____

Do you take any illicit drugs? Yes No **If so, what drugs and how much?** ____________________________

Please circle any of the following medical problems that anyone in your immediate family has/had (Mother, Father, Sister, and Brother):

Arthritis	M	F	S	B	Diabetes	M	F	S	B
High Blood Pressure	M	F	S	B	Asthma	M	F	S	B
Heart Problems	M	F	S	B	Cancer	M	F	S	B
Lung Disease	M	F	S	B	Bleeding Problems	M	F	S	B
Peptic Ulcers	M	F	S	B	Psychiatric Problems	M	F	S	B
Tuberculosis	M	F	S	B	HIV/AIDS	M	F	S	B
Kidney Problems	M	F	S	B	Alcoholism	M	F	S	B
Colitis	M	F	S	B	Drug Abuse	M	F	S	B
Hepatitis	M	F	S	B	Other Infection	M	F	S	B

Please list any surgeries you have had, including date of service:

____

____

____

List all ALLERGIES including medications, bandages/tape, and topical agents and REACTIONS:

____

____

____

List all MEDICATIONS you are currently taking, including over the counter medications:

____

____

____

Please list any other information you feel the doctor needs to be aware of:

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