CHESAPEAKE BAY ORTHOPEDICS, PC

Date: _____

Name:_____
Home Address_____ PO BOX_____
City/State:_____ Zip:_____
Phone #: _____Work#_____Cell_____
Email _____ Male / Female
Date of Birth_____ Age _____ Social Security # _____ Language _____
Ethnicity _____Race _____ Height**:**_____Weight**:**_____
Marital Status _____ Spouses Name _____ Phone:_____
Primary Dr_____ last date seen _____Who were you referred by?_____
Emergency Contact_____ Phone#:_____

Reason for today's visit (circle one) R L Both (Body Part) _____

Where it happened Home___ Work___ Auto____ Other _____ please explain_____

How this injury happened_____

Date of injury or onset of complaints: _____

Currently Working? Yes___,No____ Last day worked: _____
Have you had recent xray's for this problem? _____ if yes where & when _____
Were you seen in the ER? Yes_____ NO____ yes yes where & when _____

** Employer and Occupation:
_____

Primary Insurance

Name of Insurance _____ Policy Holder Employer _____
Member ID #_____ Group # _____
Policyholder:_____ DOB_____ SS#_____

Secondary Insurance

Name of Insurance _____ Policy Holder Employer_____
Member ID #_____Group # _____
Policyholder:_____ DOB _____ SS#_____

Medical Problems	YES	NO	Please detail ALL "YES" ANSWERS
Eye, Ear, Nose, Throat			
Sleep Apnea			
Heart Disease			
Lung Disease			
Kidney/Liver Disease			
Stomach/Intestinal Disease			
Arthritis/Bone/Joint Muscle Disease			
Diabetes			
Epilepsy			
Cancer			
Vascular Disease			
Thyroid Disease			
High Blood Pressure			
Bleeding/Clotting Disorders			
Psychiatric Problems			
High Cholesterol			
CPAP Machine			
OTHER:			

ARE YOU EXPERINCING ANY OF THESE SYMPTOMS?

Chest pain/ palpitations/irregular heart beat Yes___ No ____ if yes, explain_____
Shortness of Breath/cough Yes __ No ____ if yes, explain_____

***SURGERIES** (type): _____
_____

***MEDICATIONS** (list all medications including prescription, over the counter, vitamins & supplements) **:**
_____
_____
_____

ALLERGIES (MEDICATIONS)_____

Social History:
Do you use Tobacco? Yes____ No ____ Amount/Duration: _____
Do you use Alcohol? Yes ____ No___ Amount/Duration: _____
Do you use Recreational Drugs? Yes___ No ___ If Yes, what substance? _____
Amount/Duration: _____
Medical Marijuana Yes ___ No ____

Pharmacy Name and Phone :_____ _____

I hereby authorize Chesapeake Bay Orthopedics, PC to contact and receive information from my pharmacy, erx (surescripts) and Drs. I also agree not to receive any narcotic medication from another physician while receiving narcotic medication from Chesapeake Bay Orthopedics or I may be discharged from the practice
Do you go to pain management? _____ Where? _____

Patient/ Representative Signature:_____Date:_____

Physician Signature of Initial Review: _____Date:_____