OSSO ORTHOPEDIC & SPINE CENTER
Daron C. Hitt, M.D.
Hand & Plastic Surgery
3115 SW 89th Street • Oklahoma City, OK 73159 • PH 405-486-6800 • Fax 405-426-6441

NEW PATIENT INFORMATION

(Please Print - Fill in All Blanks)

PATIENT'S LEGAL NAME: LAST	FIRST	MIDDLE INITIAL	SEX	BIRTH DATE	AGE

SOCIAL SECURITY NO: | MARITAL STATUS: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

PATIENT'S ADDRESS: | Are You: ❑ Employed ❑ Full-Time Student ❑ Part-Time Student ❑ Retired

CITY: | STATE: | ZIP CODE: | REFERRING PHYSICIAN:

HOME PHONE: ( ) | WORK PHONE: ( ) | CELL PHONE: ( ) Is it okay to leave a message on phone number provided? ❑ Yes ❑ No

INSURANCE INFORMATION - We will need a copy of the Insurance Card in order to file a claim.

Name of the Primary Insurance Company _____

Name of the Person who carries the Insurance Policy _____ Relationship to Patient _____

Carriers DOB _____ Carriers SS# _____

Carriers Employer _____

Secondary Insurance _____

Carrier Name _____ Relationship to Patient _____

Not Applicable ❑ Carriers DOB _____ Carriers SS# _____

Carriers Employer _____

EMPLOYMENT INFORMATION

N/A ❑ Patients Employer _____ Ph# _____

N/A ❑ Insured Employer _____ Ph# _____

If the patient is a minor, please list both parents names and employer

Mother _____ Employer _____ Ph# _____

N/A ❑ Father _____ Employer _____ Ph# _____

EMERGENCY CONTACT

NEAREST RELATIVE NOT LIVING WITH YOU:

HOME PHONE: ( ) | RELATIONSHIP TO THE PATIENT:

WHO REFERRED YOU TO OUR OFFICE?

❑ Adjustor ❑ Attorney ❑ Billboard ❑ Case Manager ❑ Coach ❑ Doctor ❑ Employer ❑ Family ❑ Friend ❑ Hospital
❑ Insurance Co ❑ Magazine ❑ Neighbor ❑ Newspaper ❑ Phone Book ❑ Physical Therapist ❑ Radio ❑ School ❑ Trainer

THIRD PARTY BILLING

Is Your Injury Work Related?	❑ Yes	❑ No
Is This Injury Due To A Motor Vehicle Accident?	❑ Yes	❑ No
If Your Injury Is MVA Related Have You Obtained an Accident Report?	❑ Yes	❑ No

I hereby authorize my insurance benefits to be paid directly to the facility and the physician and I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of any insurance claims. I, acknowledge and agree that I have received a copy of the TPG Privacy Notice.

Signature _____ Date _____

Name: _____ Date: _____

Are you here for a second opinion? _____YES _____NO

Date of Injury: _____ Date symptoms began: _____

Were you injured on the job? _____YES _____NO

If yes, how did the injury happen? _____

Where? _____What time? _____

Have you been treated for this injury? _____YES _____NO

Were x-rays or tests done? _____YES _____NO

Did you bring them or a report with you? _____YES _____NO

Was surgery performed? _____YES _____NO

Date of Surgery: _____ Surgery performed: _____

Are you able to continue activities or work? _____YES _____NO

If unable to work, please give last day worked: _____

Location of pain (i.e. hand, finger, wrist): _____

PREVIOUS MEDICAL HISTORY

List all previous surgeries (name, body part and approximate date).

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

List any medications you are currently taking.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Drug allergies? _____YES _____NO

Latex allergies? _____YES _____NO

Iodine or shellfish allergy? _____YES _____NO

List any allergies and the reaction:

1. _____ Reaction: _____

2. _____ Reaction: _____

3. _____ Reaction: _____

Have you ever had any health problems? (Please check.)

_____ Heart Attack _____ Diabetes _____ High Blood Pressure

_____ Seizures _____ Blood Clots Where: _____

_____ Stomach Ulcers _____ Asthma/Lung Problems

_____ Cancer Where: _____

_____ Other: _____

FAMILY MEDICAL HISTORY

CONDITION	FAMILY MEMBER
Arthritis	
Bleeding disorder	
Cancer	
Diabetes	
Heart disease	
High blood pressure	
Stroke	
Other:	
Other:	

SOCIAL HISTORY

TOBACCO:

_____ Never

_____ Former Date Quit: _____

_____ Current How many packs per day? _____

_____ Smokeless How many cans per day? _____

Alcohol use: _____YES _____ NO DAILY / WEEKLY / OCCASIONALLY (circle one)

Marital status: _____Married _____Divorced _____Single _____Widowed

HEIGHT: _____ WEIGHT: _____

FEMALES ONLY:

Is there a chance you could be pregnant? _____YES _____ NO

In the last ***THREE*** months have you had any of the following**: (circle all that apply).**

Constitutional: Unexpected weight loss, weight gane, fever, chills, night sweats

Eyes: Corrective lens, blur/double vision, visual changes, pain, redness, watering.

Ear, Nose, Throat: Difficulty swallowing, frequent nose bleeds, bleeding bums, ear ache, ringing.

Cardiovascular: Chest pain, irregular heartbeat, palpitations, murmur.

Respiratory: Shortness of breath, wheezing, cough.

Gastrointestinal: Heartburn, nausea, vomiting, constipation, diarrhea, bloody stool, reflux.

Genitourinary: Frequency, urgency, difficult/painful urination, incontinence, blood in urine.

Musculoskeletal: Joint pain, stiffness, swelling, instability, redness, heat, pain.

Skin: Rashes, pigmentary changes, poor healing, redness, masses, skin ulcers.

Neurologic: Numbess, tingling, dizzines, seizures, headaches.

Physchiatric: Anxiety, depression, sleeping difficulties.

Heme/Lymph: Anemia, easy bruising, excessive bleeding.