VARSITY ORTHOPEDICS

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Patient Information

Name (legal): ______________________________ Name Preferred: ____________
(Last) (First) (Middle)

Today's Date: ____/____/____ ☐Male ☐Female Date of Birth: ____/____/____ Age ________

Home Address: ______________________ City/State/Zip ______________________

Race: ☐Caucasian ☐African American ☐Hispanic ☐Asia ☐Native American Other ______________

Language: ☐English ☐Spanish ☐Other ________ Could This patient be pregnant? ☐Yes ☐No

Form is being completed by: ☐Parent ☐Patient ☐Step-Parent ☐Guardian ☐Family Member ☐Other ________

Is the patient: ☐Dependent ☐Independent ☐Married ☐Pays own bills ☐In armed forces ☐Emancipated by Law

School Name: ______________________ Grade: ______________

Insurance Name: ______________________ ID # ______________

Parent Information

Mother's full Name ______________ Father's Full Name ______________

Mother's DOB ______________ Father's DOB ______________

Mother's Address ☐Check here if same as above Father's Address ☐Check here if same as above

Address ______________ Address ______________

City ________ State ____ Zip ________ City ________ State ____ Zip ________

Social Security # ______________ Social Security # ______________

Drivers Lic # ______________ Drivers Lic # ______________

Employer ______________ Employer ______________

Address ______________ Address ______________

City ________ State ____ Zip ________ City ________ State ____ Zip ________

Cell Phone ______________ Cell Phone ______________

Work Phone ______________ Work Phone ______________

Alternate Phone ______________ Alternate Phone ______________

Email ______________ Email ______________

If divorced, who has custody of child? ______________________

Who else is authorized to bring the child in for medical treatment? ______________________
Name and Relationship

Emergency contact ______________________ Relationship ______________
Provided full name of emergency contact not living with the family

Emergency contact's Primary Phone ______________ Alternate Phone ______________

Pharmacy

Pharmacy Name: ____

City: ____

Phone: ____

Referral

Primary Care Physician Name: ______________________________ PCP Phone: _____________________________

How did you hear about us? ☐Varsity Orthopedics Website ☐Internet Search ☐Medical Insurance ☐Doctor ☐Family/friend____________________ ☐Other _____________________________

Authorizations

"I verify the accuracy of the above information and I authorize the release of any medical information necessary to process any and all claims."

"I hereby authorize payment of medical benefits direct to Varsity Orthopedics. I understand all co-payments and non-covered charges are due at time of service. All cost not paid by insurance are due upon receipt of statement."

"I Acknowledge receipt of HIPPIA Notice of Privacy Practices: I have received or have been given the opportunity to receive a copy of HIPPIA Notice of Privacy Practices for Varsity Orthopedics."

Parent/Guardian Signature: ________________________________Printed Name: _____________________________

Relationship to patient: ___________________________________ Date: ___________________________________

Reason for Visit

What is the reason for today's visit? ____

____

How was the patient injured? ____

____

____

Where was the patient injured (Place)? ____

When did the problem first start (Date)? ____

What other physicians have you seen for the problem?

Emergency Room/Urgent Care Name of physician ____

Phone: ________________________________ Address: ____

City: ____ State: ______________ Zip: ________________________

What was done for you? ☐Exam ☐X-Rays ☐MRI ☐Brace ☐ Cast ☐Sling ☐ Crutches ☐Other______________________

Name of other physician seen for this condition? ____

Phone: _________________________________ Address: ____

City: ____ State: _______________ Zip: ________________________

What was done for you? ☐Exam ☐X-Rays ☐MRI ☐Brace ☐ Cast ☐ Sling ☐ Crutches ☐Other ____________________

Medical History

Birth History: ☐Normal vaginal delivery ☐C-Section reason____

Is the child up to date on immunizations? ☐Yes ☐No If not, date of last immunizations ______________________________

List surgeries and hospitalizations

Reason	**Date**	**Hospital**

List of Medical conditions

Type	**Date**

Medical History

List current medications including hormones, non-prescriptions and prescription medications

Drug Name	Dosage	Reason	Drug Name	Dosage	Reason

List any allergies with type of reaction

Allergy	Type of reaction

Does this child have a latex allergy? ☐Yes ☐No Does the child have a metal allergy? ☐Yes ☐No

Family History

Mother ☐Living ☐Deceased Cause ____

Father ☐Living ☐Deceased Cause ____

How many siblings live at home with patient? ____

List all diseases immediate family have had

Illness	Yes	Which relative(s) and age of onset
Diabetes	☐	
Stroke	☐	
Heart Disease	☐	
Congenital Syndrome	☐	
High Blood Pressure	☐	
High Cholesterol	☐	
Brittle Bone Disease (Osteogenesis Imperfecta)	☐	
Hepatitis	☐	
HIV/AIDS	☐	
Tuberculosis	☐	
Birth Defects	☐	
Drinking or Drug problems	☐	
Bone Cancer	☐	
Blue Sclera (whites of eyes)	☐	
Downs Syndrome	☐	
Mental Illness/Depression	☐	
Problems with anesthesia	☐	
Other	☐	
Other	☐	
Other	☐	
None of these	☐	

Social History

Has the patient?	Yes	No	Comments
Ever smoked?	☐	☐	Currently smoking: Packs per day: Years :
Ever drank alcohol?	☐	☐	Current consumption: Drinks per day: Drinks per week:
Ever take herbal drugs, supplements or multivitamins?	☐	☐	
Used recreational drugs?	☐	☐	
Used Steroids?	☐	☐	
Exercised regularly?	☐	☐	Current exercise: How long: How often:

Review of Systems

General		**General**	
Weakness	☐	Chills	☐
Severe Fatigue	☐	Fever	☐
Appetite changes	☐	Night sweats	☐
Sleep changes	☐	Weight loss	☐
		None of these	☐
Other general problems:			

HEENT		**HEENT**	
Difficult hearing	☐	Ear infections	☐
Wearing glasses/contact(s)	☐	Vision problems	☐
Tubes in ears	☐	Frequent sore throat	☐
Frequently ear infections	☐	Speech delay	☐
Surgery on ears	☐	**None of these**	☐
Other ear, nose, throat, or head problems:			

Cardiovascular		**Cardiovascular**	
Patent Ductus (hole in heart)	☐	Murmur	☐
Palpitations	☐	Heart surgery	☐
Abnormal rhythms	☐	Congenital defects	☐
Mitral valve prolapses	☐	**None of theses**	☐
Other heart/vascular problems:			

Respiratory		**Respiratory**	
Pneumonia	☐	Asthma	☐
Critical cough	☐	Shortness of breath	☐
Need for inhaler	☐	**None of these**	☐
Other chest/lung problems:			

Gastro-Intestinal		**Gastro-Intestinal**	
Frequent diarrhea	☐	Gastric reflux	☐
Constipation	☐	Appendicitis	☐
Intestinal problems	☐	Surgery on abdomen	☐
		None of these	☐
Other stomach, digestion or intestinal:			

Review of Systems

Genitals/Urinary		Genitals/Urinary	
Undescended testicle	☐	Frequent urinary tract infection	☐
Testicle torsion	☐	Difficulty urinating	☐
Abnormal Genitalia	☐	History of sexual abuse	☐
Bed wetting after age seven	☐	**None of theses**	☐
Other bladder/groin/genital problems or history:			

Musculoskeletal		Musculoskeletal	
Curve in back	☐	Bone disease	☐
Back pain	☐	Foot pain	☐
Fracture of bone	☐	Bowed legs	☐
Joint swelling	☐	History of physical abuse	☐
Arthritis	☐	**None of these**	☐
Other disease of muscle, joint, and or/spine:			

Endocrine		Endocrine	
AIDS	☐	Diabetes	☐
Hepatitis	☐	Thyroid disease	☐
		None of these	☐
Other hormone endocrine problems:			

Neurological		Neurological	
Tingling/numb extremities	☐	Toe walking	☐
Headaches	☐	Depression	☐
Epilepsy	☐	Anxiety	☐
Delay in sitting; crawling or walking	☐	Bipolar disorder	☐
Other nerve/brain problems:		**None of these**	☐
Other psychiatric/mental diseases			

Genetics/Congenital		Genetics/Congenital	
Down’s Syndrome	☐	Cerebral palsy	☐
Congenital syndrome	☐	arthrogryposes	☐
Myelomeningocele	☐	**None of these**	☐
Other:			