Atlantic
Health System
Atlantic Medical Group

DT120

Date: _____

Patient Name: _____

PATIENT DEMOGRAPHICS

PATIENT INFORMATION:		
Last Name:	First Name:	Date of Birth:
Address:	City:	State: Zip:
Home Phone:	Cell Phone:	
E-Mail Address:	Sex:	Religion:
Employer:	Occupation:	Work Phone:
Primary Language:	Ethnic Origin:	Race:
EMERGENCY CONTACT INFORMATION:		
Name:	Relationship:	Phone:
Can we leave a message on home/cell phone with test results? HOME: ☐ YES ☐ NO CELL: ☐ YES ☐ NO		
Can we speak to a family member about your care and test results? ☐ YES ☐ NO		
If yes, please list name(s): _____		
PRIMARY INSURANCE:		
POLICY HOLDER:		
Last Name:	First Name:	Date of Birth:
Address:	City:	State: Zip:
Relationship to Patient:		
Employer:	Employer Phone Number:	
Address:	City:	State: Zip:
Insurance Name:		
Address:	City:	State: Zip:
Insurance ID#:	Group #:	
SECONDARY INSURANCE:		
POLICY HOLDER		
Last Name:	First Name:	Date of Birth:
Address:	City:	State: Zip:
Relationship to Patient:		
Employer:	Employer Phone Number:	
Address:	City:	State: Zip:
Insurance Name:		
Address:	City:	State: Zip:
Insurance ID#:	Group #:	

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DT527

PEDIATRIC ORTHOPEDIC SURGERY INTAKE FORM

Date: _____

Patient Name: _____ Date of Birth: _____

Reason for today's visit: _____

When did the problem begin? / Date of injury: _____

_____

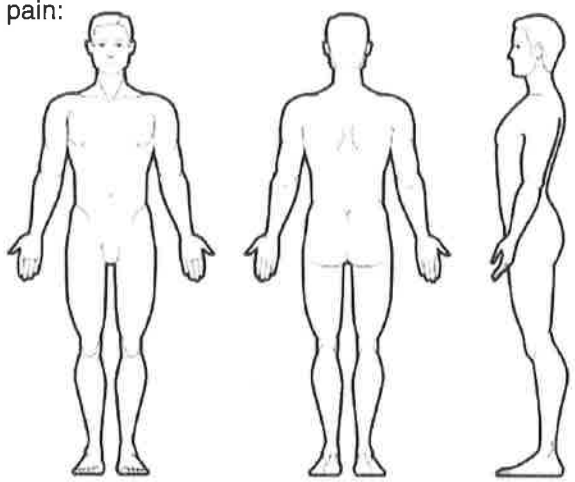
Please describe the problem/injury in detail: _____

_____

Have you been treated for this problem in the past? ☐ Yes ☐ No

If yes, please list previous treatment (PT, brace, casting): _____

Circle area(s) where you are having pain:



What makes the pain better? _____

What makes the pain worse? _____

Pain level today (1 -10): _____ Lowest last week: _____ Highest last week: _____

Please list any previous lab, x-ray, MRI, CT or any other imaging studies related to the current condition:

MRI ☐ Yes ☐ No Date(s): _____

CT ☐ Yes ☐ No Date(s): _____

X-Ray ☐ Yes ☐ No Date(s): _____

Other: _____

Have you fallen in the past year? ☐ Yes ☐ No Did it result in injury? ☐ Yes ☐ No

If yes, please describe: _____

How did you hear about our practice? _____

Patient Signature: _____ Date: _____ Time: _____

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PEDIATRIC ORTHOPEDIC SURGERY INTAKE FORM

Birth History:

Birth Weight: _____ lb. _____ oz. Full term: ☐ Yes ☐ No Weeks of Gestation: _____

Position at time of delivery: ☐ Head first ☐ Breech ☐ Other: _____

Any complications with the pregnancy, labor or delivery? ☐ Yes ☐ No

If yes, please explain: _____

Was any breathing assistance or NICU admission required? _____

Please list any physician's involvement in the patient's care: _____

Growth and Development History:

Rolled over at _____ months, sat unassisted at _____ months, walked at _____ months

Has the patient previously had Physical Therapy? ☐ Yes ☐ No Occupational Therapy? ☐ Yes ☐ No

Speech Therapy? ☐ Yes ☐ No

Does the patient use any assistive device or orthotics? _____

Social History:

Child lives with: ☐ Mother ☐ Father ☐ Siblings (how many? _____) ☐ Other: _____

Grade in school? _____

Sports/recreational activities? _____

How often do you participate in sports/recreational activities? _____

Family Medical History:

Has anyone in the family suffered from:

☐ Anesthesia Complications
☐ Bleeding/Clotting Disorder
☐ Clubfoot
☐ Hip Disorder
☐ Muscular Dystrophy
☐ Neurologic Disorder
☐ Neuromuscular Disease
☐ Other Bone/Joint Problems
☐ Scoliosis
☐ Sudden Death

Patient Signature: _____ Date: _____ Time: _____

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DT8018

PATIENT/FAMILY CONTACT LIST

Patient's Name: _____ DOB: _____

Contacts

People who have permission to receive detailed information about your care (PHI):

PRIMARY CONTACT

Name:

Relationship:

☐ Check here if you would like us to involve this person in discussions about your health care

Phone Numbers
Cell: _____ _____ _____
Home: _____ _____ _____
Other: _____ _____ _____

SECONDARY CONTACT(S)

Name:

Relationship:

☐ Check here if you would like us to involve this person in discussions about your health care

Phone Numbers
Cell: _____ _____ _____
Home: _____ _____ _____
Other: _____ _____ _____

Name:

Relationship:

☐ Check here if you would like us to involve this person in discussions about your health care

Phone Numbers
Cell: _____ _____ _____
Home: _____ _____ _____
Other: _____ _____ _____

☐ **I decline to designate a representative at this time.**

Comments/Other Information:

This form is effective upon execution and will remain in effect unless revoked by me.

Patient Signature: _____ Date: _____ Time: _____