Please **DOWNLOAD** and complete forms. Fax to (877) 287-3117, email to frontdesk@gustavelorthopedics.com, or print in advance of your appointment. Forms will be signed at your appointment.

GUSTAVEL ORTHOPEDICS

DATE: _____

REFERRED BY: _____
(MD/Coach/Trainer/Friend, etc.)

CURRENT SPORT: _____ TEAM/SCHOOL: _____

PATIENT: _____
(Last Name) (First Name) (M.I) (Preferred Name)

PATIENT ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DOB: _____ AGE: _____ SEX: M☐ F☐ SOCIAL SECURITY NUMBER: _____

CELL PHONE: _____ WORK PHONE: _____ HOME PHONE: _____

PATIENT EMPLOYER: _____

MARITAL STATUS: _____ PATIENT IS A STUDENT: Full-Time ☐ Part-Time ☐

HOW WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS? Cell Call☐ Cell Text☐ Email☐ Home Phone☐

PATIENT/GUARDIAN'S EMAIL ADDRESS: _____
(Email must belong to a patient if 18+ years of age or parent/guardian if minor)

ETHNICITY: Hispanic or Latino☐ Non-Hispanic or Latino☐ **PREFERRED LANGUAGE:** _____

RACE: American Indian **OR** Alaskan Native☐ Asian☐ Black/African American☐ White☐ Native Hawaiian **OR** Pacific Islander☐

Emergency Contact: Name: _____ Relationship: _____ Phone #: _____

Is the patient the policyholder for insurance? Yes☐ No☐ If Yes, Insurance Company: _____

Please Complete for Patient insurance, Dependent insurance, or other insured.

Spouse☐ Father☐ Mother☐ Other☐ Name: _____

DOB: _____ SSN: _____

Employer: _____ Phone #: _____ Work Phone: _____

Home Address: _____ City: _____ State: _____ ZIP: _____
(Indicate if same as patient or please complete address line above)

_____
(Insurance Company Name) (Policy ID#) (Group #)

Please Complete for Workers Compensation insurance or Motor Vehicle insurance.

_____
(Insurance Company Name and Address) (Claim Number) (Phone and Name for Agent or Representatives)

SIGN HERE _____ **Date:** _____

(***PATIENCE MUST BE 18 YEARS OR OLDER TO SIGN.*** *PARENT/GUARDIAN SIGNATURE REQUIRED UNDER 18 YEARS OF AGE*)

New Patient Intake Form

Date:

Patient's Name: _____ Date of Birth: ___/___/_____ Height: _____ Weight: _____

Occupation: _____

Chief complaint/Reason for Visit: R L _____

Date of Injury: _____ Mechanism of Injury: _____

How severe is the pain on a scale of 1-10, with 10 being the worst? _____

Type of pain (circle all that apply): Sharp Dull Pins/Needles Aching Cramping Throbbing Constant Intermittent

Who referred you to Gustavel Orthopedics? Name:_____

Circle one: ☐ Physical Therapist ☐ Physician ☐ Physician Assistant ☐ Friend/Family

Please answer the following questions:

	Current every day user	Current some day user	Former user	Never user
Do you smoke?	☐	☐	☐	☐
Do you drink alcohol?	☐	☐	☐	☐
Do you use any recreational drugs?	☐	☐	☐	☐

Past Medical History:

	Yes	No		Yes	No		Yes	No
Asthma	☐	☐	Endocrine Disorder	☐	☐	Thyroid disease	☐	☐
Atrial Fibrillation	☐	☐	Fibromyalgia	☐	☐	Stomach Ulcer	☐	☐
Bleeding Tendencies	☐	☐	Gallbladder problems, stones, or disease	☐	☐	Sleep apnea	☐	☐
Blood clots or DVT	☐	☐	Hepatitis A	☐	☐	Seizure disorder	☐	☐
Concussion	☐	☐	Hepatitis B	☐	☐	Osteoporosis	☐	☐
COPD	☐	☐	Hepatitis C	☐	☐	Osteoarthritis	☐	☐
Contacts/glasses	☐	☐	Hearing	☐	☐	MRSA	☐	☐
Emphysema	☐	☐	High blood pressure	☐	☐	Liver problems or jaundice	☐	☐
Diabetes type 1	☐	☐	HIV or AIDS	☐	☐	Kidney disease	☐	☐
Diabetes type 2	☐	☐	Problems with anesthesia	☐	☐	Other:	☐	☐

Past Surgical History:

Name: _____ Year: _____ Laterality: **R L Bilateral**

Name: _____ Year: _____ Laterality: **R L Bilateral**

Name: _____ Year: _____ Laterality: **R L Bilateral**

Name: _____ Year: _____ Laterality: **R L Bilateral**

Name: _____ Year: _____ Laterality: **R L Bilateral**

Name: _____ Year: _____ Laterality: **R L Bilateral**

New Patient Intake Form

Review of Symptoms (circle all that apply)

***General*: None**		
Overall Health	Fever	Sleep disturbance
Change in appetite	Headache	Weight loss
Chills	Lightheadedness	You or a family member has had a
Fatigue	Night sweats	problem w/anesthesia

***Allergy/immunology/ENT:* None**		
Itching	*Respiratory*:	Cough
Rash	Asthma	Shortness of breath
Seasonal allergies	Breathing problems	Wheezing
Nose/throat problems	Chest pain	

***Cardiovascular*: None**		
Chest pain	Irregular heartbeat	Weight gain
Heart problems	Swelling in hands/feet	
High blood pressure	Weakness	

***Skin:* None**		
Hives	Masses	Rash on feet
Itching	Rash	Skin cancer

***Gastrointestinal/Genitourinary*: None**		
Abdominal pain/swelling	Vomiting	Frequent urination
Heartburn	Weight loss	Kidney problems
Nausea	Blood in urine	Pain in lower back
Stomach problems	Difficulty urinating	Painful urination

***Musculoskeletal:* None**		
Arthritis/arthralgia	Joint stiffness	Painful joints
Back problems	Leg cramps	Sciatica
Carpal tunnel	Muscle aches	Swollen joints
History of gout	Pain in shoulder(s)	Weakness

***Neurologic*: None**		
Balance difficulty	Loss of strength	Paralysis
Dizziness	Loss of use of extremity	Seizures
Fainting	Low back pain	Stroke
Gait abnormality	Memory loss	Tingling/numbness
Headache	Pain	

New Patient Intake Form

Allergies:

	Please list allergy and reaction
Allergies to Medication	
Latex, Sutures, Tape, Metal, Jewelry	
Other:	

Medications you are taking

Medication Name	Strength	How many pills do you take at a time?	How often do you take these pills?

Pharmacy name and location: _____

My signature shows that I attest that all of the information provided on this sheet is correct and filled out to the best of my ability.

Signature of Patient: _____ Date: _____

Signature of Patient's Representative: _____ Date: _____

Relationship to Patient: _____