

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



DATE: \_\_\_\_\_

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

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)

PHARMACY NAME AND LOCATION: \_\_\_\_\_

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:** \_\_\_\_\_

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



Date:

New Patient Intake Form

**Review of Symptoms** (circle all that apply)

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

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

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

<b>Skin: None</b>		
Hives	Masses	Rash on feet
Itching	Rash	Skin cancer

<b>Gastrointestinal/Genitourinary: None</b>		
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

<b>Musculoskeletal: None</b>		
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

<b>Neurologic: None</b>		
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	

Date:

New Patient Intake Form

Allergies:

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

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 (please list name of all surgeries, the physician who performed it, year, and which side):

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**

Family History (please check the below boxes if a listed family member has had any medical problems):

	Heart Disease	Cancer	Arthritis	Respiratory	Other
Father					
Mother					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

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: \_\_\_\_\_