

Patient Information

Child's Legal Name _____
(First) (Middle) (Last)

Today's Date _____ Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip _____

Male Female Height _____ Weight _____ Could the patient be pregnant? Yes No

This form is being completed by: Patient Parent Step-parent Guardian Family member Other _____

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

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 _____ City _____

State _____ Zip _____ State _____ Zip _____

Social Security # _____ Social Security # _____

Employer _____ Employer _____

Address _____ Address _____

City _____ State _____ City _____ State _____

Zip _____ Work Phone _____ Zip _____ Work Phone _____

Home Phone _____ Home Phone _____

Alternate Phone _____ Alternate Phone _____

E-mail _____ E-mail _____

If divorced, who has the custody of child? _____

Who else is authorized to bring this child in for medical treatment? _____

Name & Relationship

Emergency Contact _____ Relationship _____

Provide full name of an emergency contact not living with the family

Emergency Contact's Primary Phone _____ Alternate Phone _____

Insurance

Plan Name _____ Insurance Effective Date _____
Phone _____ Address _____
City _____ State _____ Zip _____
Policy ID _____ Policy Owner _____ Group No. _____

Authorization

"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 grant Varsity Orthopedics and the physicians associated with the practice the authority to administer treatments and perform such procedures as may be deemed necessary for the patient."

"I request payment of this claim and, if the payer accepts assignment, I authorize payment directly to the physician or supplier for the services described."

Parent/guardian signature _____ Date _____

Relationship to patient _____

Reason for Visit

What is today's reason for visit? _____

How was the patient injured? _____

Where was the patient injured? _____

When did the problem first start? _____

Which other physicians have you seen for this problem?

Emergency room/urgent care: Name of physician _____

Phone _____ Address _____

City _____ State _____ Zip _____

What was done for you? _____

Other physician: Name of physician _____

Phone _____ Address _____

City _____ State _____ Zip _____

What was done for you? _____

Who referred you? _____

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 all medical conditions

Type	Date

Medical History

List current medications including hormones, nonprescription and prescription medications

Drug name	Dosage	Reason	Drug name	Dosage	Reason

List any allergies with type of reaction

Allergy	Type of reaction

Does the 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: _____

Siblings: Number living: _____ Number deceased: _____ Cause(s)/Age(s): _____

List all diseases immediate family have had:

Illness	Yes	Which relative(s) & age of onset
Diabetes	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	
Heart disease	<input type="checkbox"/>	
Congenital syndrome	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	
High cholesterol	<input type="checkbox"/>	
Brittle bone disease (Osteogenesis imperfecta)	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	
HIV/AIDS	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	
Birth defects	<input type="checkbox"/>	
Drinking or drug problems	<input type="checkbox"/>	
Bone cancer	<input type="checkbox"/>	
Blue sclera (Whites of eyes)	<input type="checkbox"/>	
Down's syndrome	<input type="checkbox"/>	
Mental illness/depression	<input type="checkbox"/>	
Problems with anesthesia	<input type="checkbox"/>	
Other	<input type="checkbox"/>	
Other	<input type="checkbox"/>	
Other	<input type="checkbox"/>	

Social History

Has the patient	Yes	No	Comments
Ever smoked?	<input type="checkbox"/>	<input type="checkbox"/>	Current smoking: Packs per day: Years:
Ever drank alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Current consumption: Drinks per day: Drinks per week:
Ever taken herbal drugs, supplements or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	
Used recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
Used steroids?	<input type="checkbox"/>	<input type="checkbox"/>	
Exercised regularly?	<input type="checkbox"/>	<input type="checkbox"/>	Current exercise: How long: How often:

Review of Systems

General	Now	Past	General	Now	Past
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Chills	<input type="checkbox"/>	<input type="checkbox"/>
Severe fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>
Appetite changes	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Sleep changes	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Other general problems:	None of these			<input type="checkbox"/>	<input type="checkbox"/>

HEENT	Now	Past	HEENT	Now	Past
Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	Eye infections	<input type="checkbox"/>	<input type="checkbox"/>
Wears glasses/contact(s)	<input type="checkbox"/>	<input type="checkbox"/>	Vision problems	<input type="checkbox"/>	<input type="checkbox"/>
Tubes in ears	<input type="checkbox"/>	<input type="checkbox"/>	Frequent sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Speech delay	<input type="checkbox"/>	<input type="checkbox"/>
Surgery on ears	<input type="checkbox"/>	<input type="checkbox"/>	None of these	<input type="checkbox"/>	<input type="checkbox"/>
Other ear, nose, throat or head problems:					

Cardiovascular	Now	Past	Cardiovascular	Now	Past
Patent ductus (hole in heart)	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal rhythms	<input type="checkbox"/>	<input type="checkbox"/>	Congenital defects	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	None of these	<input type="checkbox"/>	<input type="checkbox"/>
Other heart/vascular problems:					

Respiratory	Now	Past	Respiratory	Now	Past
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Need for inhaler	<input type="checkbox"/>	<input type="checkbox"/>	None of these	<input type="checkbox"/>	<input type="checkbox"/>
Other chest/lung problems:					

Gastro-intestinal	Now	Past	Gastro-intestinal	Now	Past
Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Gastric reflux	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	Surgery on abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Other stomach, digestion or intestinal problems:	None of these			<input type="checkbox"/>	<input type="checkbox"/>

Genitals/urinary	Now	Past	Genitals/urinary	Now	Past
Undescended testicle	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>
Testicular torsion	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal genitalia	<input type="checkbox"/>	<input type="checkbox"/>	History of sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>
Bed wetting after age seven	<input type="checkbox"/>	<input type="checkbox"/>	None of these	<input type="checkbox"/>	<input type="checkbox"/>
Other bladder/groin/genital problems or history:					

Musculoskeletal	Now	Past	Musculoskeletal	Now	Past
Curve in back	<input type="checkbox"/>	<input type="checkbox"/>	Bone disease	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	Foot pain	<input type="checkbox"/>	<input type="checkbox"/>
Fracture of bone	<input type="checkbox"/>	<input type="checkbox"/>	Bowed legs	<input type="checkbox"/>	<input type="checkbox"/>
Joint swelling	<input type="checkbox"/>	<input type="checkbox"/>	History of physical abuse	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	None of these	<input type="checkbox"/>	<input type="checkbox"/>
Other disease of muscles, joints, and/or spine:					

Endocrine	Now	Past	Endocrine	Now	Past
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Other hormone/endocrine problems:			None of these	<input type="checkbox"/>	<input type="checkbox"/>

Neurological	Now	Past	Neurological	Now	Past
Tingling/numb extremities	<input type="checkbox"/>	<input type="checkbox"/>	Toe walking	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy (seizures)	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Delay in sitting, crawling or walking	<input type="checkbox"/>	<input type="checkbox"/>	Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>
Other nerve/brain problems:			None of these	<input type="checkbox"/>	<input type="checkbox"/>
Other psychiatric/mental diseases:					

Genetics/congenital	Now	Past	Genetics/congenital	Now	Past
Down's syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>
Congenital syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Arthrogryposis	<input type="checkbox"/>	<input type="checkbox"/>
Myelomeningocele	<input type="checkbox"/>	<input type="checkbox"/>	None of these	<input type="checkbox"/>	<input type="checkbox"/>
Other:					