DR. ANDREW MARTIN

Board Certified Orthopedic Surgeon

"KeepMoving...Life'sWaiting"

PATIENT REGISTRATION

LAST NAME:_____ FIRST NAME_____ MI:___

DATE OF BIRTH:_____ (mm/dd/yyyy) SEX:____ RACE:_____ ETHNICITY_____

SOCIAL SECURITY #:_____ ADDRESS:_____

ADDRESS 2:_____ CITY:_____ STATE:_____ ZIP:_____

LANGUAGE:_____ LANGUAGE COUNTRY:_____

MARITAL STATUS: __SINGLE __MARRIED __PARTNER __DIVORCED __WIDOWED

__PREGNANT (check if applicable) __NURSING (check if applicable)

Whom may we thank for referring you to our practice?_____

CONTACT INFORMATION

HOME PHONE:_____ WORK PHONE:_____ EXT_____

CELL PHONE:_____ EMAIL:_____

EMERGENCY CONTACT INFORMATION

FIRST NAME:_____ LAST NAME:_____

HOME PHONE:_____ CELL:_____

RELATIONSHIP TO PT:_____ CONTACT ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HIPAA APPROVED CONTACTS: (PERSON OF CONTACT THAT YOU AUTHORIZE TO SPEAK ON YOUR BEHALF / AUTHORIZE US TO RELEASE MEDICAL INFORMATION)

FIRST NAME:_____ LAST NAME:_____ DOB_____

RELATIONSHIP:_____ PHONE NUMBER:_____

PRIMARY CARE / OTHER PHYSICIANS

PHYSICIAN NAME:_____ PRACTICE NAME:_____

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

PHARMACY NAME:_____ PHARMACY PHONE:_____

PHARMACY LOCATION:_____

By signing below, I attest that the information provided above is true and accurate.

Signature of Insured / Guardian:_____ Date:_____

Office 702.898.2663 Fax 702.304.2663
5546 Fort Apache Road #100 | Las Vegas 89148
www.docmartinortho.vegas

Adult Hip, Knee, Shoulder Reconstruction & Sports Medicine

INSURANCE INFORMATION

INSURANCE COMPANY:_____ COPAY:_____

GROUP#:_____ SUBSCRIBER #:_____

INSURED FIRST NAME:_____ LAST NAME:_____

SOCIAL SECURITY #:_____ DOB_____ RELATIONSHIP TO PT:____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____
PHONE#:_____ EXT:_____
ADVANCED DIRECTIVE? ___YES ___NO WHERE IS FILED?_____(what medical facility?)

INSURED EMPLOYED BY:_____ BUSINESS ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____ BUSINESS PHONE #:_____

ADDITIONAL INSURANCE:
IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? ____YES ____NO

INSURANCE COMPANY:_____ COPAY:_____

GROUP#:_____ SUBSCRIBER#:_____

INSURED FIRST NAME:_____ LAST NAME:_____ MI:_____

SOCIAL SECURITY #:_____ DOB:_____ RELATIONSHIP TO PATIENT:_____

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

PHONE#_____ EXT:_____

INSURED EMPLOYED BY:_____

BUSINESS ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____
BUSINESS PHONE #:_____

EMPLOYEMENT STATUS: ___EMPLOYED ___UNEMPLOYED ___RETIRED ___FULL TIME STUDENT
___PART TIME STUDENT
LAST DEGREE EARNED: ___HIGH SCHOOL ___COLLEGE ___GRADUATE SCHOOL
OCCUPATION:_____ BUSINESSNAME:_____
BUSINESS PHONE:_____
DRIVERS LICENSE #:_____ STATE ISSUED:_____
IS THIS AN ACCIDENT? ___YES ___NO DATE OF INJURY:_____
IS THIS A MOTOR VEHICLE ACCIDENT? ___YES ___NO

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT
By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian:_____ **Date:**_____

Name _____ Date of birth _____

Address _____

Local phone number _____ Alternative phone number _____

Please describe what problem or concern brought you to our office today:

☐ Initial Consult ☐ Post-Op Appointment

☐ Referring Physician _____

Personal Health History

Please check past(P) or current(C) problems or conditions

P ☐ C ☐ Hypertension	P ☐ C ☐ Atrial Fibrillation	
P ☐ C ☐ High cholesterol	P ☐ C ☐ Stomach ulcer	
P ☐ C ☐ Diabetes	P ☐ C ☐ Seizures	
P ☐ C ☐ Heart attack or angina	P ☐ C ☐ Headaches	
P ☐ C ☐ Irregular heart rhythm	P ☐ C ☐ Stroke	
P ☐ C ☐ Congestive heart failure	P ☐ C ☐ Prostate problem	
P ☐ C ☐ Asthma	P ☐ C ☐ Breast problem	
P ☐ C ☐ Emphysema or chronic bronchitis	P ☐ C ☐ Urinary tract infections	
P ☐ C ☐ Gastroesophageal reflux disease	P ☐ C ☐ Arthritis	
P ☐ C ☐ Pneumonia	P ☐ C ☐ Thyroid problem	
P ☐ C ☐ Osteoporosis/Osteopenia	P ☐ C ☐ Bleeding disorder	
P ☐ C ☐ Kidney Disease, Type:	P ☐ C ☐ Addiction Issues	
P ☐ C ☐ Liver Disease, Type:	P ☐ C ☐ Depression	
P ☐ C ☐ Bowel/digestive problem	P ☐ C ☐ Anxiety	
P ☐ C ☐ Cancer, Type:	P ☐ C ☐ Mental Illness	
	☐ Other:	

Previous Surgical Procedures

Please check if you have had any of the following:

Procedure	Year
☐ Heart surgery	
☐ Carotid artery surgery	
☐ Vascular surgery / stent	
☐ Abdominal aneurysm repair	
☐ Hysterectomy Ovaries Rem.? ☐ Y ☐ N	
☐ Gallbladder removed	
☐ Appendix removed	
☐ Intestinal Surgery	
☐ Joint replacement ☐ Hip ☐ Right ☐ Left ☐ Knee ☐ Right ☐ Left	
☐ Spine Surgery ☐ Neck ☐ Back	
☐ Breast cancer surgery	
☐ Prostate cancer surgery	
☐ Hernia	
☐ Other: _____	

Social History:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner

Live here year round? ☐ Yes ☐ No If no, Part time location: _____

Occupation: Concerns: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting

Tobacco use: ☐ Never ☐ Quit (when)_____ ☐ Current smoker: Packs/day, how many years_____

Alcohol use: ☐ No ☐ Yes If yes how many drinks/how often_____

Caffeine use: ☐ No ☐ Yes If yes, ☐ Coffee ☐ Soda ☐ Tea how many drinks/how often_____

Illicit Drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current

Describe: _____

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically, have any of your relatives had the following conditions?

Condition	Relative	Condition	Relative
☐ Mental illness		☐ Chemical dependency	
☐ Diabetes		☐ Stroke	
☐ Thyroid Disease		☐ Arthritis	
☐ Pituitary Disease		☐ Dementia	
☐ Chrohn's/Colitis		☐ Hypertension	
☐ Cancer, Type: _____		☐ Other:	

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Hospital Admissions (excluding pregnancies):

Date	Hospital	Reason for admission

Allergies:

Please list any allergies to medications or foods

Name	Symptom/Reaction

Medications:

Please list any medications that you take, including over the counter medications, herbs, and supplements:

Name	Dose	Freq.	Name	Dose	Freq.

Pharmacy: _____ Phone: _____ Store #: _____

Location Description: _____