SOMERSET ORTHOPAEDICS, INC.

Patient Information
Please complete all lines

PATIENT INFORMATION:

PATIENT NAME: ____
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

NAME OF PARENT/GUARDIAN IF UNDER 18: ______________________________

ADDRESS: ____________________ CITY: ____________ STATE: ______ ZIP: __________

HOME PHONE: ______________ WORK PHONE: ______________ CELL PHONE: ______________

SEX: M/F (circle one) D.O.B. ______________ SOCIAL SECURITY NUMBER: ______________

MARITAL STATUS: Single/ Married/Widowed/ Separated/ Divorced

FAMILY/REFFERRING PHYSICIAN: ______________________________

EMPLOYMENT STATUS: Full-time/ Part-time/ Retired/ Self-Employed/ Unemployed/ Student

EMPLOYER ______________________ OCCUPATION ______________________

EMPLOYER ADDRESS: ______________________________

PHARMACY: ______________________________

DO YOU HAVE A POWER OF ATTORNEY? Circle Yes/No If yes, please provide the name and number. ______________

POLICY HOLDER /RESPONSIBLE PARTY INFORMATION:

Are you the policy holder for your health insurance? Circle Yes/No If yes, please skip this section. If no, please complete the following:

POLICY HOLDER NAME: ______________________________

RELATIONSHIP TO PATIENT: ______________ SS#: ______________ D.O.B. ______________

EMERGENCY CONTACT INFORMATION:

NAME/RELATIONSHIP: ______________________________ PHONE: ______________

MEDICAL HISTORY

Are you currently taking any medications? Please circle Yes/No If yes, please provide a list to be copied or use the space provided to write the names and dosages.

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Do you have any allergies? (drug, food or environmental) Circle Yes/No If yes, please list your allergies and the reaction.

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Please list all chronic medical conditions: (Diabetes, High blood pressure etc…) ______________________________

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