

PLEASE PRINT CLEARLY and FILL OUT COMPLETELY

PATIENT NAME \_\_\_\_\_ HOME PHONE (\_\_\_\_) \_\_\_\_\_  
ADDRESS \_\_\_\_\_ BUS. PHONE (\_\_\_\_) \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ EMER/CELL PHONE (\_\_\_\_) \_\_\_\_\_  
AGE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SEX \_\_\_\_\_ PATIENT SS# \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ JOB TITLE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ SPOUSE/PARENT NAME \_\_\_\_\_  
SPOUSE/PARENT EMPLOYER \_\_\_\_\_ CITY, STATE \_\_\_\_\_

PRIMARY INS. \_\_\_\_\_ ID# \_\_\_\_\_ GROUP# \_\_\_\_\_  
SUBSCRIBER NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SELF \_\_\_ SPOUSE \_\_\_ PARENT \_\_\_  
2<sup>ND</sup> INS. \_\_\_\_\_ ID# \_\_\_\_\_ GROUP# \_\_\_\_\_  
SUBSCRIBER NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SELF \_\_\_ SPOUSE \_\_\_ PARENT \_\_\_

REASON FOR VISIT \_\_\_\_\_ **R or L BOTH** WHEN DID IT START \_\_\_\_\_  
HOW DID YOU GET HURT? \_\_\_\_\_ AUTO ACC? \_\_\_ WORK RELATED? \_\_\_ FALL? \_\_\_  
TREATMENT TO DATE: \_\_\_\_\_

**MEDICATIONS** PLEASE LIST ALL MEDICATIONS, HERBAL SUPPLEMENTS, THE DOSAGES AND FREQUENCY YOU ARE TAKING.  
(OR PROVIDE LIST) \_\_\_\_\_ **NONE**

**MEDICINE ALLERGIES** ASPIRIN \_\_\_\_\_ SULFA \_\_\_\_\_ PENICILLIN \_\_\_\_\_ NOVOCAIN \_\_\_\_\_ OTHER \_\_\_\_\_ **NONE**

**PATIENT MEDICAL HISTORY** PLEASE **CIRCLE** THE FOLLOWING IF YOU HAVE OR DID HAVE / **NONE**

ASTHMA \_\_\_\_\_ BLEEDING TENDENCIES \_\_\_\_\_ BLOOD CLOTS \_\_\_\_\_ CANCER \_\_\_\_\_ CHRONIC GI DISORDERS \_\_\_\_\_ DIABETES \_\_\_\_\_ GI BLEED \_\_\_\_\_ GOUT \_\_\_\_\_  
HEART DISEASE \_\_\_\_\_ HIGH BLOOD PRESSURE \_\_\_\_\_ KIDNEY DISEASE \_\_\_\_\_ LUNG DISEASE \_\_\_\_\_ PSORIASIS \_\_\_\_\_ STROKE \_\_\_\_\_  
RHEUMATOID ARTHRITIS \_\_\_\_\_ THYROID DISEASE \_\_\_\_\_ ULCERS \_\_\_\_\_ SLEEP APNEA \_\_\_\_\_ SNORING \_\_\_\_\_

EXPLAIN: \_\_\_\_\_

**PRIOR SURGERIES** \_\_\_\_\_ **NONE**

DO YOU SMOKE? **YES** PKS/DAY \_\_\_\_\_ **NO** DRINK ALCOHOL? **YES** **NO** HAVE YOU USED DRUGS? **YES** **NO**

**FAMILY HISTORY** PLEASE **CIRCLE** THE FOLLOWING IF YOUR BLOOD RELATIVES HAVE / **NONE**

ASTHMA \_\_\_\_\_ BLEEDING TENDENCIES \_\_\_\_\_ BLOOD CLOTS \_\_\_\_\_ CANCER \_\_\_\_\_ CHRONIC GI DISORDERS \_\_\_\_\_ DIABETES \_\_\_\_\_ GI BLEED \_\_\_\_\_ GOUT \_\_\_\_\_  
HEART DISEASE \_\_\_\_\_ HIGH BLOOD PRESSURE \_\_\_\_\_ KIDNEY DISEASE \_\_\_\_\_ LUNG DISEASE \_\_\_\_\_ PSORIASIS \_\_\_\_\_  
RHEUMATOID ARTHRITIS \_\_\_\_\_ STROKE \_\_\_\_\_ THYROID DISEASE \_\_\_\_\_ ULCERS \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ PREGNANT? YES NO Last Menstrual Period Date \_\_\_\_\_

FAMILY DOCTOR \_\_\_\_\_ REFERRED BY? \_\_\_\_\_  
\*\*DOCTOR ADDRESS/PHONE \_\_\_\_\_

I REQUEST THAT PAYMENT OF MEDICARE AND/OR INSURANCE BENEFITS BE MADE TO SOBEL-ZELL ORTHOPAEDIC ASSOCIATES, P.C. FOR ANY SERVICES FURNISHED TO ME. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ACCEPT RESPONSIBILITY FOR ANY UNCOVERED REMAINING BALANCE OF MY BILL.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SOBEL & ZELL ORTHOPAEDIC ASSOCIATES, P.C. 525 ROUTE 73 SOUTH, SUITE 303, MARLTON NJ 08053 (856)596-0555

PLEASE GIVE YOUR INSURANCE CARDS TO THE RECEPTIONIST