Delray Orthopaedic Center Registration Form
5130 Linton Blvd. Suite B2 Delray Beach FL
Phone 561 665 7701, Fax 561 665 7702

NAME:_____

HOME ADDRESS:_____

CITY_____**STATE**_____**ZIP**_____

BIRTH DATE:_____ **AGE:**_____

SEX: ☐ **Male** ☐ **Female** **Marital Status:** ☐ **Married** ☐ **Divorced** ☐ **Single** ☐ **Widowed**

PHONE NUMBERS: Preferred Contact: ☐ **Cell** ☐ **Work** ☐ **Home**

CELL:_____**WORK:**_____**HOME:**_____

EMAIL:_____

SOCIAL SECURITY NUMBER:_____

WHO REFERRED YOU TO US:_____

EMERGENCY CONTACT:_____**PHONE**_____

EMPLOYER AND ADDRESS:_____

_____

EMPLOYER PHONE NUMBER:_____

REASON FOR VISIT:_____ ☐ **Work Related** ☐ **Auto Injury**

DATE OF INJURY:_____ ☐ **Personal Injury/Lawsuit Related**

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE:_____

GROUP NUMBER:_____**POLICY NUMBER:**_____

PATIENTS RELATIONSHIP TO THE SUBSCRIBER: ☐ **Self** ☐ **Spouse** ☐ **Other**

NAME OF SECONDARY INSURANCE:_____

GROUP NUMBER:_____**POLICY NUMBER:**_____

PATIENTS RELATIONSHIP TO THE SUBSCRIBER: ☐ **Self** ☐ **Spouse** ☐ **Other**

THE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

Patient/Guardian Signature:_____**Date:**_____

Name:_____

Height:_____ Weight:_____

Pharmacy Name:_____Phone#_____

Street:_____City:_____State:_____Zip code:_____

***Primary Doctor**

First and last name:_____

Phone number:_____Fax:_____

Address:_____City:_____State:_____Zip code:_____

Patient Signature:_____Date:_____

Print Patient Name:_____Signature:_____

Past Medical History:

None	Yes	No
Anxiety	Yes	No
Asthma	Yes	No
Atrial Fibrillation	Yes	No
Bipolar Disorder	Yes	No
Stroke	Yes	No
Anemia	Yes	No
COPD	Yes	No
Chronic Pain	Yes	No
Coronary artery disease	Yes	No
Blood clots (Legs)	Yes	No
Blood clots (Lungs)	Yes	No
Depression	Yes	No
Diabetes	Yes	No
Type 1 Type 2		
Kidney disease	Yes	No
Epilepsy	Yes	No
High Blood Pressure	Yes	No
GERD (reflux)	Yes	No
HIV	Yes	No
High Cholesterol	Yes	No
Hyperthyroidism	Yes	No
Hypothyroidism	Yes	No
Liver Disease	Yes	No
Cancer Please specify		
_____	Yes	No
Fibromyalgia	Yes	No
Sleep Apnea	Yes	No
Rheumatoid Arthritis	Yes	No

Allergies:

_____
_____
_____
_____

Social History:

Alcohol Yes No
No. per day_____
Smoking Yes No
No. per day_____

Living Will	Yes	No
Health Care Proxy	Yes	No
Pneumonia Vaccine	Yes	No
Flu Vaccine this year	Yes	No
Covid Vaccine	Yes	No

Print Patient Name:_____Signature:_____

Medications with Dose and Frequency:

May Provide List

_____
_____
_____
_____
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_____
_____

Past Surgical History:

NONE: _____

PLEASE LIST OPERATIONS BELLOW

_____
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_____

Family History:

Mother: _____

Father: _____

Print Patient Name:_____Signature:_____

Review of Systems:

Joint pains	Yes	No	Depression	Yes	No
Joint swelling	Yes	No	Hallucinations	Yes	No
Joint stiffness	Yes	No	Blood thinners	Yes	No
Unsteady walking/standing	Yes	No	Pacemaker	Yes	No
Numbness	Yes	No	Defibrillator	Yes	No
Tingling	Yes	No	Require meds for procedures	Yes	No
Unexpected weight loss	Yes	No	Rheumatoid arthritis	Yes	No
Fever	Yes	No	Chronic pain syndrome	Yes	No
Chills	Yes	No	Allergy to shellfish/iodine	Yes	No
Poor healing wounds	Yes	No	Allergy to latex	Yes	No
Redness	Yes	No	Allergy to adhesive	Yes	No
Rash	Yes	No	Under pain management	Yes	No
Easy bleeding	Yes	No	Pregnant or planning a pregnancy	Yes	No
Easy bruising	Yes	No			
Chest pain	Yes	No	Anxiety	Yes	No
Heart murmur	Yes	No			
Excessive thirst or urination	Yes	No			
Nose bleeds	Yes	No			
Eyeglasses or contact lenses	Yes	No			
Blurred vision	Yes	No			
Nausea/vomiting	Yes	No			
Constipation	Yes	No			
Bloody/Tarry stools	Yes	No			
Painful/Difficult urination	Yes	No			
Shortness of breath	Yes	No			
Cough	Yes	No			

Print Patient Name:_____Signature:_____