JOSEPH P. SPOTT, D.O.
Orthopedic Spine Surgery
Orthopedic Surgery

9430 Wicker Ave. St. John, IN 46373 219-558-8068
2020 E. Columbus Dr., Suite B East Chicago, IN 46312 219-397-8648

PATIENT INFORMATION

DATE: _____

NAME: _____ (LAST / FIRST / MI) ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE

ADDRESS: _____ (STREET / APT # / CITY / STATE / ZIP)

BIRTHDATE _____ (MO DAY YEAR) PHONE: _____ (HOME) _____ (OFFICE) _____ (Mobile)

PLACE OF EMPLOYMENT (OR SCHOOL): _____ GRADE: ____ Social Security # _____

RACE: _____ ETHNICITY: _____ LANGUAGE: _____

WHO REFERRED YOU TO OUR OFFICE? _____ Email Address _____

INSURANCE INFORMATION

	PRIMARY	SECONDARY
SUBSCRIBER:	_____ (LAST / FIRST / MI)	_____ (LAST / FIRST / MI)
INSURANCE CO.	_____	_____
ADDRESS:	_____ (STREET / CITY / STATE / Zip)	_____ (STREET / CITY / STATE / ZIP)
TELEPHONE:	_____	_____
ID# / GROUP #	_____ (ID NUMBER) / _____ (GROUP #)	_____ (ID NUMBER) / _____ (GROUP #)

PERSON'S NAME WHO HOLD'S INSURANCE: _____ Date of Birth: _____ Social Security: _____

PLEASE PROVIDE THE RECEPTIONIST WITH THE INSURANCE CARDS FOR DUPLICATION

PERSON TO CONTACT (OUTSIDE OF IMMEDIATE FAMILY) IN CASE OF EMERGENCY

NAME: _____ (LAST / FIRST / MI) TELEPHONE: _____ (HOME) _____ (OFFICE)

ADDRESS: _____ (STREET / APT # / CITY / STATE / ZIP)

NOTICE

A charge will be made for all appointments not cancelled within 24 hours of the appointment. Payment is expected when services are rendered unless other arrangements are made in advance.

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, certify that I (or my dependant) have insurance coverage with the above company(ies) and assign directly to Joseph P. Spott, D.O. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I, also give consent to have my prescriptions sent out electronically through the pharmacy provided.

X _____ (SIGNATURE OF INSURED / GUARDIAN) DATE _____

I have been given the choice to obtain a copy of the Privacy Act. I have read it and understand my rights.

Patient Signature

If Minor Guardian

Date

Superior Orthopedics

Dr. Joseph P. Spott D.O.

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Confidential Information

Date of Exam:_____ Age:_____ Date of Birth:_____
Patient Name (please print)_____ M F
Last First Middle Initial

Referring Physician:_____ Family Physician:_____
Height_____ Current Weight._____ Weight one year ago: _____

What health problem brought you here today?_____

PAST MEDICAL HISTORY

Heart Disease	No	Yes	Hypertension	No	Yes	Stroke	No	Yes
Cancer	No	Yes	Type:_____			Treatment _____		
Diabetes	No	Yes	Controlled by: insulin	Oral medication	diet controlled	Age of onset:		
Transmissible Diseases	No	Yes	History of TB	Recent TB exposure	Positive TB skin test			
			Hepatitis A	Hepatitis B	Hepatitis C	HIV positive	AIDS	Other

SURGERY Have you had surgery? Please list type of operation and year
1._____ 2. _____
3._____ 4. _____

Problems with Anesthesia Yes No Prolonged Paralysis Problems Walking Up Malignant Hyperthermia

MAJOR ILLNESS Please list major hospitalizations for medical problems you have had (diagnosis and year)
1. _____ 2._____
3. _____ 4. _____

MEDICATIONS:
Please list all medications including weight loss and nonprescription medication with dosage and frequency
1._____ 2. _____
3._____ 4. _____
5._____ 6. _____

ALLERGIES Do you have a latex allergy? Yes No
Please list any allergies that you have and what reaction you have.
1. _____ 2._____
3. _____ 4._____
5. _____ 6._____

Are you required to take antibiotics prior to surgery or dental work? No Yes

MEDICAL REVIEW
Have you had or do you now have any of the following?

General Health No Recent fever unexplained weight loss fatigue frequent illness

Eye Problems No Glasses Contacts Blindness Cataracts Glaucoma Prosthetic Eye Vision Difficulty

Ears Nose Throat No Hearing loss Deaf Hearing aids Frequent sinus infections Swallowing Problems

Cardiovascular No Angina Irregular Heartbeat Heart Attack Heart Murmur Rheumatic Fever
Heart Failure High Blood Pressure Low Blood Pressure Blood Vessel Blockage
Heart surgery Pacemaker Valve replacement Implantable Defib Device
Date of last EKG: 0ther:

Respiratory No Emphysema COPD Asthma Sleep Apnea Shortness of Breath TB
Date of last chest x-ray: _____ Other: _____

Intestinal No Ulcers Hemorrhoids Ostomy Hiatal Hernia Cirrhosis Yellow jaundice
Gallstone Other _____

Urinary No Renal failure Dialysis Prostate Enlargement Urinary tract infection Kidney stones
Prostate Infections Other: _____

Musculoskeletal No Broken bones: (if so what) _____ Joint replacement
Limited back movement Limited neck movement Decrease in muscle size
Decrease in muscle strength Other: _____
Have you had: Neck injury? Yes No Back injury? Yes No

Integument (Skin) No Changing moles Skin lesions Breast lump Other: _____

Neurological No Epilepsy Stroke TIA Migraines Speech difficulties Mute Parkinson's
Alzheimer's Multiple sclerosis Head injury Other: _____
Are you Right handed__ Left handed__ Ambidextrous__

Psychiatric No Nervous Breakdown Depression Schizophrenia Manic depression Other:

Endocrine No Hypothyroid Hyperthyroid Menstrual Irregularity Other:

Hematological No Swollen Lymph Nodes Anemia Blood loss Transfusion Leukemia Lymphatic
Other _____

Are there any other medical problems we should be aware of: Yes No If yes, please explain

FAMILY HISTORY: Please circle any of the following if they are present in any of your family members
Cancer Diabetes Epilepsy Heart Trouble Stroke High Blood Pressure Muscular Disease
Connective Tissue Disease Mental Illness Tuberculosis _____

Please complete the following:

	Age if Living	State of Health if Living	Age at death	Current Illnesses or Cause of Death
Father		Good Fair Poor		
Mother		Good Fair Poor		
Brothers and Sisters Number Living Number Dead				

Tobacco Use
Do you smoke? Yes No Did you ever smoke? Yes No If yes, when did you quit? _____
How many years have / did you smoke? _____ How many packs per day? _____
Do you use chewing tobacco? Yes No

Alcohol Use
Do you, or did you ever, use alcohol regularly? Yes No If yes, how much?
Have you been treated for alcoholism? Yes No If yes, when? _____
Do you, or did you ever, use illicit drugs regularly? Yes No If yes, how much? _____
Have you been treated for drug addiction? Yes No If yes, when? _____

Immunizations: (Circle immunization and date received):
Flu Shot _____ Pneumovac _____ Tetanus _____ Hepatitis _____
Polio _____ Date of last TB test _____

For Females:
When was your last menstrual period? _____ Are you pregnant or could you be pregnant? Yes No
Are your periods regular? Yes No Hysterectomy? Yes No

Have you ever used birth control pills? Yes No if yes, when and for how long? _____

For Males:
Erection problems Yes No Impotency Yes No

SOCIAL HISTORY:
I currently live: _in a house _apartment _mobile home _retirement center _other
_on first floor _other level _in a place where I climb stairs daily
_live alone _live with family _I currently have home care / visiting nurse

Patient's Caregiver: at home *("self" or give name, relationship to patient with phone number they can be reached at)*

_____

If primary caregiver is someone other than patient are they in good health? Yes No
Level of Education: Grade school High school College Post College

Job History:
Employer: _____ Job title: _____

Have you had to alter your job as a result of the problem that brought you here today? No Yes
(if yes please explain) _____

If you are currently off work as a result of this problem? Yes No How long have you been off work? _____

If appropriate, please circle the level of work your normal job involves:

Physical Demands level of Work:	SEDENTARY	LIGHT	MEDIUM	MEDIUM HEAVY	HEAVY	VERYHEAVY
Occasional 0-33%	10 lbs.	20 lbs.	50 lbs.	75 lbs	100 lbs.	over 100 lbs
Frequent 34-66%	0	10 lbs	20 lbs	35 lbs	50 lbs	over 50 lbs
Constant 67-100%	0	0	10 lbs	15 lbs	20 lbs	over 20 lbs.
Office work						

Is the reason you are being seen due to a work related injury? No Yes
If you are being seen today for an injury is there a lawsuit involved? No Yes Possible

Prior jobs	Type of Work	Length of employment
1.		
2.		
3.		

PAIN ASSESSMENT: (if applicable)
Location and description:

What Releaves Your Pain? Worsens It?

Please circle the number that reflects your current pain level at rest.
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worse Pain

Please circle the number that reflects your current pain level while performing your normal activities.
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worse Pain

Please circle the number that reflects your current pain level while performing your job.
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worse Pain

Information provided by: _____
Signature of Patient or Family Member *Relationship to Patient* *Date*