ADVANCED
HAND & PLASTIC SURGERY CENTER

## Patient Demographics Update Form

Name: _____ Date of Birth: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Address: _____ City, State, Zip: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Primary Care Physician: _____ PCP Phone #: _____

Injured at Work (Y or N): ___ If yes, how? _____ Date of Injury: _____

**Spouse or Parent Information:**

Name: _____ Phone #: _____

**Emergency Contact Information:**

Name: _____ Phone #: _____

Relationship: _____

**Primary Insurance Information:**

Company Name: _____ Member ID #: _____ Group #: _____

Subscriber Name: _____ Subscriber SSN: _____

Subscriber Date of Birth: _____ Insurance Claims Address: _____

City, State, Zip: _____ Insurance Phone #: _____

**Secondary Insurance Information:**

Company Name: _____ Member ID #: _____ Group #: _____

Subscriber Name: _____ Subscriber SSN: _____

Subscriber Date of Birth: _____ Insurance Claims Address: _____

City, State, Zip: _____ Insurance Phone #: _____

**Do you use a pharmacy exclusively? If so, please list the name and phone #:**

_____

What is the primary reason for your visit today? _____
_____
_____
_____

**Past Hospitalizations (over 24 hours):** ☐Yes ☐No

If YES, please state reason(s): _____
_____

**What MEDICATIONS are you currently taking? (Please check all that apply)**

☐ I am NOT currently taking ANY medications

| | | | | |
|---|---|---|---|---|
| ☐ Albuterol | ☐ Coumadin | ☐ Hydrocodone | ☐ Lortab | ☐ Plavix |
| ☐ Aspirin | ☐ Crestor | ☐ Insulin | ☐ Metformin | ☐ Tetracycline |
| ☐ Augmentin | ☐ Keflex | ☐ Metoprolol | ☐ Oxycodone | ☐ Toprol |
| ☐ Celebrex | ☐ Glyburide | ☐ Lasix | ☐ Oxycontin | ☐ Ultram |
| ☐ Cephalexin | ☐ HCTZ | ☐ Lipitor | ☐ Penicillin | ☐ Zoloft |

Other Medications: _____
_____

**Are you currently seeing a Pain Management doctor?**

☐ Yes (Initial) _____ ☐ No (Initial) _____

Doctor's Name: _____

**Medical History (Please check all that apply)**

☐ I have no medical problems

| | | |
|---|---|---|
| ☐ Anxiety | ☐ Depression | ☐ Kidney Problems (Please explain below) |
| ☐ Asthma | ☐ Diabetes (Type 1/Type2) | ☐ Lung Problems (Please explain below) |
| ☐ Bipolar | ☐ Peripheral Vascular Disease | ☐ Heart Problems (Please explain below) |
| ☐ Cancer | ☐ High Blood Pressure | ☐ Rheumatoid Arthritis |
| ☐ COPD | ☐ High Cholesterol | ☐ Thyroid Problems (Please explain below) |

Other Medical Conditions: _____
_____

**Allergies (Please check all that apply)**

☐ I have no known drug allergies (NKDA)

| | | |
|---|---|---|
| ☐ Ciprofloxacin | ☐ IV Dye | ☐ Sulfa Drugs |
| ☐ Codeine | ☐ Latex | ☐ Tape/Adhesive |
| ☐ Erythromycin | ☐ Penicillin | ☐ Tetracycline |
| ☐ Iodine | ☐ Steroids | ☐ Tylenol |

Other Allergies: _____
_____

## Past Surgical History (Please check all that apply)

- ☐ I have no surgical history

- ☐ Adenoidectomy
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Cosmetic Surgery
- ☐ C-Section (Cesarean)
- ☐ Endoscopy
- ☐ Eye Surgery
- ☐ Gall Bladder Removal
- ☐ Gastric Bypass
- ☐ Heart Surgery
- ☐ Hemorrhoid Surgery
- ☐ Hernia Surgery
- ☐ Hysterectomy
- ☐ Neck Surgery
- ☐ Oral Surgery
- ☐ Prostate Surgery
- ☐ Reconstructive Surgery
- ☐ Stent Placement
- ☐ Stomach Surgery
- ☐ Thyroid Surgery
- ☐ Tonsillectomy
- ☐ Trigger Finger Release
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Wound Care
- ☐ Breast Biopsy
  - ☐ Right
  - ☐ Left
  - ☐ Both
- ☐ Carpal Tunnel
  - ☐ Right
  - ☐ Left
  - ☐ Both
- ☐ Cubital Tunnel
  - ☐ Right
  - ☐ Left
  - ☐ Both
- ☐ Elbow
  - ☐ Right
  - ☐ Left
  - ☐ Both
- ☐ Knee
  - ☐ Right
  - ☐ Left
  - ☐ Both
- ☐ Shoulder
  - ☐ Right
  - ☐ Left
  - ☐ Both

Other Surgeries: _____
_____

## Review of Systems (Please check all that apply)

- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Elbow Pain
  - ☐ Right
  - ☐ Left
  - ☐ Both
- ☐ Shoulder Pain
  - ☐ Right
  - ☐ Left
  - ☐ Both

- ☐ Radiating Pain from Hand to Extremity
  - ☐ Right
  - ☐ Left
  - ☐ Both
- ☐ Numbness/Tingling in the Hand(s)
  - ☐ It DOES get worse at night
  - ☐ It DOES NOT get worse at night

I hereby grant permission to Advanced Hand and Plastic Surgery Center, LLC to employ such medical and surgical procedures as my doctor may consider necessary in my diagnosis and treatment. I authorize the hold of medical or other information to release to my insurance carrier, any information needed for this or related insurance change. I agree to pay any charges incurred by me to the Advanced Hand and Plastic Surgery Center, LLC.
I hereby grant permission for the use of any of my medical records including illustrations, photographs, or other imaging records created in my case for use in examination, testing, credentialing, and/or presentations purposes by Advanced Hand and Plastic Surgery Center, LLC.
**Consent for Treatment:** The undersigned, hereby voluntarily consent to medical care/diagnostic treatment and/or minor surgical treatment by the physicians of Advanced Hand and Plastic Surgery Center, LLC deemed advisable and necessary in the diagnosis and treatment of any condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records for treatment. I hereby grant permission for the use of any of my medical records including illustrations, photographs, or other imaging records created in my case for use in examination, testing, credentialing, and/or presentations purposes by Advanced Hand and Plastic Surgery Center, LLC.

Signature of Patient: _____ Date: _____