Gregory D. Riebel, MD
Minimally Invasive Spine Specialist & General Orthopaedist, ABOS, AAOS
Preston A. Waldrop, MD
Sports Medicine & General Orthopaedist, ABOS, AAOS
Mark L. Hagy, MD
Foot, Ankle, Knee Specialist & General Orthopaedist, ABOS, AAOS, AAFAOS
Dr. James Farmer, MD
AAOS, ISAKOS, AOSSM

Christian Conrad, PA-C
AAPA
R. Michael Wilson, PA-C
AAPA, VAP
John D'Alessandro, PA-C
AAPA, VAP
Mackenzie Prandi, PA-C
NCCPA

PLEASE PRINT

Date ______________________ **Best number to contact you at** ______________________

Patient Information

Name ______________________ Soc. Sec. # ______________________

Address ______________________

City ______________________ State ________ Zip ______________________

Email ______________________

Sex M F Age ________ Birthdate ______________ Single Married Widowed Separated Divorced

Patient employed by ______________________ Occupation ______________________

Business Address ______________________ Business Phone ______________________

Primary Care Physician ______________________ Whom may we thank for referring you? ______________________

In case of emergency, who should be notified? ______________________ Phone ______________________

How do you prefer to receive your appointment reminder? Phone Text Email (please circle)

Primary Insurance

Person responsible for account ______________________
Last Name First Name Initial

Relation to patient ______________________ Birthdate ______________ Soc. Sec. # ______________________

Address (if different from patient's) ______________________ Phone ______________________

City ______________________ State ________ Zip ______________________

Person responsible employed by ______________________ Occupation ______________________

Business Address ______________________ Business Phone ______________________

Insurance Company ______________________

Contract # ______________ Group # ______________ Subscriber # ______________

Names of other dependents covered under this plan ______________________

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber name ______________________ Relation to patient ______________ Birthdate ______________

Address (if different from patient's) ______________________ Phone ______________________

City ______________________ State ________ Zip ______________________

Subscriber employed by ______________________ Occupation ______________________

Business Address ______________________ Business Phone ______________________

Insurance Company ______________________ Soc. Sec. # ______________________

Contract # ______________ Group # ______________ Subscriber # ______________

Names of other dependents covered under this plan ______________________

Assignment & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with ______________________
Name of Insurance Company(ies)

and assign directly to **Virginia Orthopaedic** 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

Responsible Party Signature ______________________ Relationship ______________ Date ______________

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New Patient/New Problem Intake Information

(Please complete every question)

Date: ____ ____________

Name: ______________________________ Age: __________ DOB: ______________

Primary Care Doctor: ____

Reason for today's visit (Please specify **RIGHT or LEFT**): ______________________________

____

Date of Surgery: ________________ Height: ________________ Weight: ________________

How Problem Started: ____

Date of injury (if any): ____________________ Is this problem work related? ____________

CURRENT MEDICATIONS:		**MEDICAL ALLERGIES:**	

Past Medical History: (circle Yes or No)

Heart Disease	Y	N
Heart Attack	Y	N
Irregular Beat	Y	N
Heart Failure	Y	N
Stroke	Y	N
Cancer	Y	N
If yes, what kind? ____________		
Depression	Y	N
Anxiety	Y	N
Blood Clots (DVT)	Y	N
Hepatitis	Y	N
Hyperlipidemia / High Cholesterol	Y	N
Diabetes	Y	N
Insulin Dependent?	Y	N
Blood Pressure	Y	N
Asthma	Y	N
COPD	Y	N
Lung Problems	Y	N
Rheumatoid Arthritis	Y	N
Seizures	Y	N
Sleep Apnea	Y	N
Cpap Machine	Y	N
Thyroid	Y	N
Hyper / Hypo (Circle one)		
Stomach Ulcers	Y	N
GERD	Y	N

OTHER MEDICAL CONDITIONS NOT LISTED:

____________ ____________ ____________ ____________

____________ ____________ ____________ ____________

What treatment have you had to date? (circle) Injection Surgery Medication Brace

PAST SURGICAL HISTORY (list all surgeries):

____________ ____________ ____________ ____________

____________ ____________ ____________ ____________

Are you disabled? ________ Yes ________ No If yes, from ________ to ________

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New Patient/New Problem Intake Information

(Please complete every question)

Family Medical History: (significant medical problems)

Father: ______________________ Mother: ______________________

Brother/Sister: ______________________ Grandparents: ______________________

Social History:

Employer/Type of Work: ______________________

Married Y N

Smoke Y N How Much? ______________________

Alcohol Y N Circle: Rarely Occasionally Frequently

Review of Systems ***(circle if applicable)*****:**

General:	fever	chills	night sweats	weight loss	loss of appetite
Skin:	rashes	bruising	discoloration		
Head:	headaches	dizziness	seizures	stroke	
Eyes:	visual changes	loss of vision			
Ears:	ringing in ears	vertigo	hearing loss		
Mouth/Throat:	dental disease	hoarseness	throat pain		
Respiratory:	cough	shortness of breath	wheezing	other	
Cardiovascular:	chest pain	swelling in ankles	dizziness	valve disease	
Gastrointestinal:	difficulty swallowing	nausea	vomiting	bowel changes	
Urinary:	frequnecy	hesitancy	pain with urination	blood in urine	
Endocrine:	excessive thirst	skin or hair changes	cold intolerance		
Musculoskeletal:	joint pain	joint swelling	arthritis	muscle pain	

Where? ______________________

Neurological:	memory loss	depression	weakness	numbness

I certify that the above information is correct to the best of my knowlege.

Signature: ______________________