TROY ORTHOPEDIC ASSOCIATES

PATIENT NAME:____**DATE:**____________________

DOB:_____________________**HEIGHT:**___________________**WEIGHT:**________________

HEALTH INSURANCE:

INSURANCE PLAN	PROVIDER NAME	POLICY NUMBER
1.		
2.		

EMERGENCY CONTACT INFORMATION: **ADVANCED DIRECTIVE / LIVING WILL** ☐ **YES** ☐ **NO**

NAME: ______________________________________**PHONE:**_______________________________

NAME:______________________________________**PHONE:**_______________________________

FAMILY PHYSICIAN:______________________________**PHONE:**_______________________________

REFERRING PHYSICIAN:____________________________**PHONE:**_______________________________

SPECIALIST: (Cardiologist, Pulmonologist, etc.)

1.________________________________**Specialty:**_____________________**Phone:**______________

2.________________________________**Specialty:**_____________________**Phone:**______________

3.________________________________**Specialty:**_____________________**Phone:**______________

CURRENT MEDICATION:

MEDICATION NAME	DOSE	HOW OFTEN DO YOU TAKE THIS MEDICATION?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

ALLERGIES:

1.____________________________________**REACTION:**___________________________________

2.____________________________________**REACTION:**___________________________________

3.____________________________________**REACTION:**___________________________________

SURGICAL AND PROCEDURAL HISTORY: (EKG, Echocardiogram, Stress Test, Cardiac Catheterization History)

1.____**DATE:**_____________________

2.____**DATE:**_____________________

3.____**DATE:**_____________________