

Pennsylvania Orthopedic Associates, Inc.

Patient Name _____ D.O.B. _____ Age _____ M _____ F _____

Address _____ City _____ State _____ Zip _____

Telephone # _____ Work # _____ Cell # _____

Marital Status: Married _____ Single _____ Other _____ Social Security # _____

Chief Complaint: _____

How did injury occur: _____

Date of injury _____ Place of injury _____

Primary Physician _____ Telephone # _____

Who referred you to us? _____ Telephone # _____

Name of employer _____ Telephone # _____

Address _____ City _____ State _____ Zip _____

Work Related: Yes No Auto Related: Yes No If so, when? _____

Have X-rays been taken? Yes No If so, when and where? _____

Are you out of work due to this condition: Yes No If so, since when? _____

If not work related or an auto accident, when did your injury occur? _____

If you were injured at work: Claim # _____

Adjuster Name _____ Telephone _____

Primary health insurance _____

Address _____ City _____ State _____ Zip _____

Policy # _____ I.D. # _____

Do you Smoke? Yes No Cigarettes Pipe Cigar

How long have you smoked? _____ How much do you smoke? _____

Do you drink alcohol? Yes No How Much? _____

Height: _____ Weight: _____

BRIEFLY ANSWER THE FOLLOWING QUESTIONS AS BEST YOU CAN (IF NONE, ANSWER "NONE")

Major Surgeries: _____

Chronic Illnesses: _____

Medications: _____

Drug Allergies: _____

Are you taking any herbal (or non-prescription medications)? _____

Patient/Guardian Signature _____ Date _____

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