Dan Samani MD, PC

New Patient Information

Patients Name _____ Social Security No _____

Address _____
(Street or Route) (City) (State) (Zip)

Occupation _____ Date of Birth _____ Age _____ Sex M Marital Status _____

Home Phone _____ Cell Phone # _____ Yes ☐ No ☐ Leave Medical Message on answering machine.
Contact: ☐ Cell ☐ Home Phone

Employer _____ Business Phone _____
Employer's Address _____
(Street or Route) (City) (State) (Zip)

Height: _____ Weight _____

Referring Doctor _____ Primary Provider _____
Address _____ MD, DO, APRN, PA MD

Clinic Name _____
Address _____
City/State/Zip _____
Phone# _____
Fax# _____

Would you object to our contacting your Doctor for any additional information pertaining to your health? YES☐NO☐

When was your last physical examination? _____

Responsible Party (if other then patient) _____ DOB _____ SSN _____
Address _____
(Street or Route) (City) (State) (Zip)

Who to contact in case of emergency: _____
Phone _____ Address _____

Date of Injury _____

Is this Work Related ☐Yes ☐No Is this Auto Related ☐Yes ☐No
Explain Injury:

Insurance Information

Primary Insurance _____
Address _____
City & State _____
Name of Policy Holder _____
Policy Holders Date of Birth _____
Policy ID Number _____
Group Number _____
Phone Number _____

Secondary Insurance _____
Address _____
City & State _____
Name of Policy Holder _____
Policy Holders Date of Birth _____
Policy ID Number _____
Group Number _____
Phone Number _____

Does your insurance Company require prior authorization for procedures and/or hospitalization? ☐Yes ☐No

Workmans Comp Info.

History

Please describe the pain or problem you are having: _____

_____

If having pain please **DESCRIBE** type, location and severity (0-10scale): _____

_____

Have you consulted with another doctor about this problem? (Orthopaedic, Surgeon or other Physician?)
If so, Who and when?

_____

Have you had any **previous injury** in this area? _____

Have you had any **previous surgery** in this area? _____

When, and what, if anything was done? _____

Where you satisfied with the results? _____

If not, Why? _____

Have you had any other **ORTHOPAEDIC** (bone or joint) surgery? ☐ Yes ☐ No

If yes, describe **WHAT** was done with **DATES** of procedures:

_____

_____

_____

_____

_____

_____

Are you **Right** or **Left** handed? (Circle one) Right

Treatment prior to Orthopedic Consult:

Did you try a Tylenol / Motrin / Ibuprofen / for at least 3 weeks to decrease pain in joint?

_____

Have you trialed home exercise or Physical Therapy for 12 weeks? _____

Circle Appropriate Response and Explain

Are you taking any Drugs or Medications? ☐ YES ☐ NO

List **ALL** medications including dose and frequency taken (be sure to include diet pills, vitamins, and herbal supplements)

Medication	Dose	Frequency/ (am or pm)

Please give us the NAME and PHONE NUMBER of you PHARMACY
failure to complete may delay your prescription

_____

ALLERGIC i.e., medications, tape, LATEX? **Type of Reaction:** i.e. hives / nausea

_____
_____
_____
_____

Please list all **OTHER SURGERIES** you have had (other than orthopaedic), including the approximate month and year, and the hospital where it was performed:

_____
_____
_____
_____
_____
_____
_____
_____

Did you have any problems with anesthesia when you had surgery?

If yes, please explain: _____

Have you ever had a blood transfusion? Any reactions? _____

Do you have any of the following	YES	NO
Heart trouble or chest pain	☐	☐
Asthma or Lung problems	☐	☐
High Blood Pressure	☐	☐
Diabetes	☐	☐
Ulcers or GERD	☐	☐
Convulsions or Seizures	☐	☐
HIV/AIDS	☐	☐
Hepatitis	☐	☐
Have you been treated for depression	☐	☐
Do you Smoke	☐	☐
Do you Drink alcoholic beverages daily	☐	☐
Anemia	☐	☐
Claustrophobic	☐	☐

Anything else that the doctor should know? _____

_____

_____

_____

RESET FORM

COMMUNITY MEDICAL CENTER
FALLS CITY, NEBRASKA

3307 Barada Street – P.O. Box 399 – Falls City, NE 68355-0399
Phone: (402) 245-6522 – www.cmcfc.org

Do you accept the fact that every medical and surgical treatment is associated with risks and complications?

(In other words complications can occur in spite of the best efforts of your physician?)

Yes ☐ No ☐

In the event you have surgery with sedation, do you give consent for your surgeon to act in your best interests and perform any additional procedures deemed necessary to treat unanticipated, (but related) conditions?

Yes ☐ NO ☐

Signature:_____

Date:_____

(Parent is asked to sign for patients under the age 18)