Arkansas Children's Hospital
Orthopaedic New Patient Intake

Complete the following and fax back to the
ACH Orthopaedic office at 501-364-1522. Thank you.

Date: ______________________ ACH #: ______________________

Patient Information

Patient Name: ______________________ Gender: ________ Age: ________ DOB: ________

SSN#: ______________________ Has the patient ever been seen at ACH? ☐ Yes ☐ No

Interpreter Needed? ☐ Yes ☐ No Language? ______________________

Mother's Full Name: ______________________ Name of Guardian (if other than parents): ______________________

Patient's Address: ______________________ City, State, Zip: , ______________________

Parent's Home Phone #: ______________________ Mom's Work #: ______________ Dad's Work #: ______________

Parent's Cell Phone #: ______________________ Parent's Message Phone #: ______________________

Intake Data:

Office Contact Person: ______________________ Office Phone #: ______________

Referring Physician: ______________________ Office Fax #: ______________

Primary Care Physician (if different from referring): ______________________ PCP Phone #: ______________

______________________ PCP Fax#: ______________

Insurance Informaion: (Fax copy of insurance information OR complete the following)

Primary Insurance		Secondary Insurance	
Insurance Name:	______________	Insurance Name:	______________
Policy Number:	______________	Policy Number:	______________
Group Number	______________	Group Number	______________

If insurance, is referral required? ______________ (If yes, please send back with this form.)

Treatment Information: Fax copies of related clinical notes & test results OR complete the following)

Diagnosis and Reason for Referral: ______________________

Duration of Problem: ______________________

Brief History of Treatment: ______________________

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Diagnosis due to Injury: ☐ Yes ☐ No

X-rays / Labs? ☐ Yes ☐ No Results: ______________________

(Please have patient bring recent x-ray / lab results to the appointment)

Physician or Clinic Preference, if applicable: ______________________

If Appropiate, Is Nurse Practitioner Clinic Acceptable? ☐ Yes ☐ No

Comments: ______________________

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Name or person taking intake: ______________________

For ACH Ortho Office Use Only

APPOINTMENT SCHEDULED

Date: ______________ Clinic: ______________ Time: ______________

Comments: ______________________

Signature: ______________________ Notification Sent: ______________________

CODE (Please Circle)

ARONSON	BLASIER	APN CLINIC
NA NEW	NA NEW	HAND CLINIC
ADD ON NEW	ADD-ON NEW	BONE TUMOR CLINIC
	NA FX CLINIC	
	ADD-ON FRACTURE	