Appointment Date:_____

Appointment Time:_____

KENTUCKY ORTHOPEDIC CLINIC

Patient ID # _____

PATIENT INFORMATION SHEET

DATE:_____SOCIAL SECURITY#:_____MARITAL STATUS: S M D W

NAME:_____ DATE OF BIRTH:_____ AGE:_____SEX: M F

PHYSICAL ADDRESS:_____CITY_____STATE_____ZIP_____

MAILING ADDRESS: _____CITY_____STATE_____ZIP_____

HOME PHONE:_____CELL PHONE:_____WORK PHONE:_____

MAY WE LEAVE APPOINTMENT INFORMATION ON YOUR VOICEMAIL OR ANSWERING MACHINE: Y N

E-MAIL: _____ MAY WE CONTACT YOU VIA TEXT OR E-MAIL: Y N

IF PATIENT IS A MINOR, PLEASE LIST PARENT OR GUARDIAN

FATHER / MOTHER_____SS#_____DOB_____

REFERRING PHYSICIAN: _____ PHARMACY:_____CITY:_____

REASON FOR VISIT:_____HOW LONG HAVE YOU HAD THIS PROBLEM:_____

INSURANCE INFORMATION

NAME OF INSURANCE:_____ POLICY HOLDER:_____

POLICY HOLDER DOB:_____ RELATIONSHIP:_____

DATE OF ACCIDENT: _____ WORKER'S COMP OR AUTO RELATED

NAME OF ATTORNEY:_____NAME OF ADJUSTER :_____

IN CASE OF EMERGENCY, PLEASE NOTIFY THE FOLLOWING INDIVIDUAL(S)

NAME:_____ RELATIONSHIP :_____ PHONE #_____

NAME:_____ RELATIONSHIP :_____ PHONE #_____

PLEASE SIGN BELOW

I hereby authorize payment of medical benefits to Dubin Orthopaedic Centre, P.S.C. for professional services rendered as well as authorizing the release of any information necessary to process this claim. I also grant Dubin Orthopaedic Centre, P.S.C. permission to release copies of my records to my family and/or referring physicians. I understand that for some reason if my insurance company refuses payment for services rendered by Dubin Orthopaedic Centre, P.S.C. , that these will become my responsibility.

_____

Signature of *Patient* or Legal Guardian **Date**

Acknowledgment Of Receipt of Notice of Privacy Practices

By signing this form I acknowledge that I have been provided with Dubin Orthopaedic Centre, P.S.C. Notice of Privacy Practices to review and informed that I may keep a copy of reference or obtain a copy upon request.

_____

Signature of *Patient* or Legal Guardian **Date**

PATIENT MEDICAL HISTORY

NAME:_____ **DATE:**_____ **PATIENT ID #:** _____

FAMILY/REFERRING PHYSICIAN:_____ **HEIGHT:**_____ **WEIGHT:**_____

RACE: _____ **LANGUAGE:**_____

OCCUPATION:_____ **JOB DUTIES:**_____

_____

CHIEF COMPLAINT:_____ **RIGHT OR LEFT SIDE?**

IS THIS A CHRONIC PROBLEM?_____ **HOW LONG HAVE YOU BEEN HAVING THE PAIN?** _____

OR A NEW INJURY? _____ **WHEN & HOW DID YOU GET THIS INJURY?** _____

_____

TESTS PERFORMED FOR THIS PROBLEM: X-RAY MRI CT/CAT SCAN EMG/NCV NERVE TESTING SURGERY

WHERE WERE THEY DONE? _____

LIST ALL MAJOR OPERATIONS: _____

_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

_____

LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:_____

_____

TOBACCO USE:

SMOKER: ☐ **SMOKELESS TOBACCO:** ☐

IF SO, HOW MUCH: > ½ PACK/DAY☐ **½-1 PACK/DAY**☐ **1 PACKS/DAY** ☐ **1-2 PACK/DAY** ☐ **<2 PACKS/DAY** ☐

NON-SMOKER: ☐ **NEVER**☐ **QUIT**☐ **IF SO, WHEN DID YOU QUIT?** _____

PLEASE MARK ANY OF THE FOLLOWING ILLNESSES THAT EFFECT YOU or YOUR FAMILY

HYPERTENSION ☐**YOU** ☐**FAMILY**_____ **LUNG DISEASE** ☐**YOU** ☐**FAMILY**_____

HEART DISEASE ☐**YOU** ☐**FAMILY**_____ **KIDNEY DISEASE** ☐**YOU** ☐**FAMILY**_____

DEPRESSION ☐**YOU** ☐**FAMILY**_____ **ALCOHOLISM** ☐**YOU** ☐**FAMILY**_____

DIABETES ☐**YOU** ☐**FAMILY**_____ **THYROID DISEASE** ☐**YOU** ☐**FAMILY**_____

CANCER ☐**YOU** ☐**FAMILY**_____ **OTHER**_____ ☐**YOU** ☐**FAMILY**_____