

Appointment
Date: _____



Patient ID # _____

Appointment
Time: _____

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 _____

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 #: _____

REFERRING PHYSICIAN: _____ PHARMACY: _____ CITY: _____

HEIGHT: _____ WEIGHT: _____ RACE: _____ LANGUAGE: _____

PLACE OF WORK: _____ WORK PHONE: _____

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: > 1/2 PACK/DAY 1/2-1 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 IMMEDIATE FAMILY (PLEASE SPECIFY THE RELATIONSHIP)

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 _____