Muskogee Bone & Joint New Patient Information Sheet

Patient's Legal Name_____Sex___ Date of Birth _____

Address_____City_____State___Zip_____

Phone (Home)_____ (Cell)_____ (Work)_____

Social Security # _____ Marital Status _____ Language _____ Race_____

Email Address _____

Work Status: Full-time, Part-time, Retired, Disabled, Unemployed, or Student

Employer:_____Referring Physician:_____
Are you under hospice care? Y/N Name of facility_____

Are you under skilled nursing care? Y/N Name of facility_____

Emergency Contact_____ Relationship_____ Phone_____

If Patient is a minor, Responsible party?_____

DOB:_____SSN#_____

Primary Insurance

Name of Insurance _____ Effective Date _____

Policy ID/Subscriber ID # _____Group/Acct#_____

Co-Pay Amount_____ Name of Policy Holder_____

Policy Holder's Date of Birth_____Policy Holder's SS#_____

Relationship to Policy Holder_____

Secondary Insurance

Name of Insurance _____ Effective Date _____

Policy ID/Subscriber ID # _____Group/Acct#_____

Co-Pay Amount_____ Name of Policy Holder_____

Policy Holder's Date of Birth_____ Policy Holder'sSS#_____

Relationship to Policy Holder_____

Past Medical History			
( ) High Blood Pressure	( )Diabetes	( ) Hepatitis	( ) Ulcers
( ) Congestive Heart Failure	( ) Asthma	( ) Cancer	( ) COPD
( ) Kidney Failure	( ) Heart Disease	( ) Stroke	( ) Seizure disorder
( ) Rheumatoid Arthritis	( ) Chronic Pain	( ) High Cholesterol	( ) Bleeding Order ( ) None

PAST SURGICAL HISTORY

( ) Back Surgery	Right or Left	Describe
( ) Neck Surgery		
( ) Arthroscopic Knee Surgery		
( ) Shoulder Surgery	Right or Left	
( ) Arthroscopic Shoulder Surgery	Right or Left	
( ) Hand Surgery	Right or Left	
( ) Wrist Surgery	Right or Left	
( ) Hip Replacement	Right or Left	
( ) Knee Replacement	Right or Left	
( ) Carpel Tunnel Surgery	Right or Left	
( ) Ankle Surgery	Right or Left	
( ) Foot Surgery	Right or Left	
( ) Hysterectomy		
( ) Gall Bladder Removal		
( ) Heart Bypass Surgery		
( ) Heart Valve Surgery		
( ) Other:		
( ) Other:		
( ) Other:		
( ) None		

( ) Smoke? Yes or No How much?	( ) Use Walker/Cane/Crutches
( ) Chew Tobacco? Yes or No How much?	( ) Use Wheelchair
( ) Drink Alcohol? Yes or No How much?	( ) Live in nursing home
( ) Illegal Drugs Which?	( ) Live in Assisted Living
Do you drink Caffeine? Yes or No	Do you have children? Yes or No

FAMILY HISTORY

Disease	**Family**
( ) Cancer	
( )Diabetes	
( )Bleeding Disorder	
( )Rheumatoid Arthritis	
( ) Heart Disease	
( )Lupus	
( )Epilepsy	
( ) Muscular Dystrophy	
( ) NONE	

Allergies/Sensitivities/To Medication

( ) None ( ) Codeine ( ) Hydrocodone ( ) Oxycodone
( ) Morphine ( ) Demerol ( ) Penicillin ( ) Sulfa Drugs ( ) Iodine
( ) Latex ( ) Cephalosporin ( ) Other:

Medications

Pharmacy:_____Location:_____

Medication Name Dose Frequency_____

___None

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

13.

Present Illness

Main Problem:_____

Is this visit due to a work injury? Yes or No

Is this visit due to an Automobile Accident? Yes or No

When did your symptoms start?_____

Where did the injury happen?_____

Have you had this problem before? Yes or No

Rate your pain on a scale of 1-10_____

What makes the pain worse?_____

Have you been treated for this before? Yes or No By Whom?_____

Have you had Physical Therapy? Yes or No Where?_____

Have you had medications for this problem? Yes or No If yes, What?_____

Have you had the following tests?

Xrays Yes or No If so, Where?_____

CT Scans Yes or No If so, Where?_____

MRI Yes or No If so, Where?_____

If yes, did you bring the report? Yes or No

Statement of Financial Responsibility, assignment of benefit, and authorization to release information. I hereby authorize, from this day forward, any insurance company whom I subscribe with to pay directly to MBJSM clinic charges for services rendered. This also applies to Medicare, health maintenance organizations and/or any other third party payers. Regulations pertaining to Medicare and other third party payers assignment of benefits apply. I authorize MBJSM, it's employees, or agents to release to the social security administration and health care financing administration/intermediaries, Medicare, or other insurance carriers and information necessary for processing insurance claims. I understand that I am responsible for all charges made to me and/or my family's account and it's my responsibility to notify MBJSM of any changes pertaining to my insurance coverage and/or my account.

_____ Date:_____

Signature of Patient or Guardian