Patient Profile

Doctor: _____

PATIENT INFORMATION

Name: _____

Address: _____

_____

City, State: _____

Phone: _____ [ ] Home [ ] Work [ ] Other

Phone: _____ [ ] Home [ ] Work [ ] Other

Patient ID #: _____ Sex: [ ] M [ ] F

Date of Birth: _____

Social Security #: _____

Marital Status: [ ] Married [ ] Single [ ] Divorced

Referring Physician: _____

Primary Physician: _____

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Unemployed [ ] Other

Phone: _____

Employer: _____

CONTACTS

_____

_____

_____

GUARANTOR

[ ] Same as Patient

Name: _____

Address: _____

_____

City, State: _____

GUARANTOR EMPLOYMENT

Employer: _____

Phone: _____

Guarantor Phone: _____

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Insured Party: _____

Insured Phone: _____

Company: _____

Relationship to Primary Insured/Guarantor: _____

Insured Social Security #: _____

Insured ID: _____

Policy Group: _____

Insured Date of Birth: _____

SECONDARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Insured Party: _____

Insured Phone: _____

Company: _____

Relationship to Primary Insured/Guarantor: _____

Insured Social Security #: _____

Insured ID: _____

Policy Group: _____

Insured Date of Birth: _____

Why are you here to see us? _____

Date of Injury _____

Is this a work related injury? [ ] Yes or [ ] No

Have you had previous surgery on what you are being seen for today? [ ] Yes or [ ] No

Orthopedic Intake

Patient Name: _____

General Medical History Form

History of Present Illness

Referring physician: _____ Primary care physician: _____

You are: ___ R handed, ___ L handed, ___ Ambidextrous

DATE OF INJURY: _____ Is this Work Comp? Yes ___ No ___ Motor Vehicle Accident? Yes ___ No ___

Where did you get hurt? Home / School / Work / Store / Car (*circle one*)

How did you get hurt?_____

Past Medical History/Conditions/Disease: circle all that apply

Anemia	Diabetes	Hypothyroidism	Poor circulation
Angina	Diabetic Foot Ulcers	Irregular Heart Beat	Pregnant? ___ No ___ Yes
Anxiety	Dialysis	Kidney Failure	Pulmonary Embolism
Asthma	Diverticulitis	Liver problems	Reflux
Bleeding Disorder	Emphysema		Rheumatoid Arthritis
Blood Clot	GI Bleed	Lupus	Seizures
Cancer, type/status?	Heart Attack	Migraines	Sleep Apnea
Chronic Back Pain	Hepatitis A, B, C	Neurological Disorder	Stroke
Congestive Heart Failure	High Blood Pressure	Numbness/Tingling	Ulcers
Depression	HIV	Urinary Tract Infection	Other

Allergies to medications/medical equipment/list type of reaction it caused:

_____

Medications/Supplements or Over the Counter Drugs: (*Use back of this sheet if more space is needed*)

Name of medication	Strength/Dose	Reason for medication

Surgical History: (*Use back of this sheet if more space is needed*)

Surgeries or Hospitalizations	Year	Complications (if any)

Medical History: Overall level of physical health is: ____ Excellent ____ Very Good ____ Good ____ Fair ____ Poor

Immunizations up-to-date? ____ Yes ____ No

Have you ever had any complications from surgery? ____ Yes ____ No

Have you ever had any complications with anesthesia? ____ Yes ____ No

If yes, describe _____

_____

Orthopedic Intake

Patient Name: _____

Family History

Has anyone in your family had: (check all that apply):

___ Anesthesia problem	___ Cancer	___ Heart Attack-Male under age 55	___ Osteoporosis
___ Bleeding Disorder	___ Diabetes	___ Heart Attack-Female under age 65	___ Rheumatoid Arthritis

Social History

Marital status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed
Children: ___ Yes ___ No

Do you live alone? ___ No ___ Yes If no, who do you live with? _____
Do you wear glasses or contacts? ___ No ___ Yes If yes, which one? _____

Occupation: _____
What kind of work? ___ Physical ___ Sedentary ___ Retired ___ Homemaker
Regulary Duty Light Duty Off work since _____ Reason: _____

Risk Factors

Current smoker? ___ No ___ Yes _____ # packs/day for _____ years
Quit smoking? ___ This year ___ over 1 year ago ___ over 5 years ago ___ over 10 years ago
Previously smoked? _____ # packs/day for _____ years
History of substance/drug abuse? ___ No ___ Yes What? _____
Drink alcohol? ___ No ___ Occasionally ___ Frequently
Exercise? ___ Daily ___ Weekly ___ Monthly ___ Rarely ___ Never
What type of exercise? _____

Review of systems: Are you currently having or have you had problems within the last 2 weeks with:
Please circle all that apply and explain if necessary.

General health:	Fever/Chills	Fatigue	Sleep Problems
Eyes:	Blurry vision	Double vision	
Ears/Nose/Throat:	Decreased hearing	Sore throat	Ears ringing
Cardiovascular:	Chest pain	Fainting	
Respiratory:	Shortness of breath	Cough	
Gastrointestinal:	Heartburn	Constipation	Nausea/Vomiting/Diarrhea
Genitourinary:	Pain on urination	Incontinence	Increased frequency
Musculoskeletal:	Joint swelling	Cramps	Weakness
Dermatological:	Rash	Itching	
Neurological:	Numbness/Tingling	Loss of Balance	
Psychological:	Anxiety	Depression	
Endocrine:	Weight change	Thirsty all the time	
Hematology:	Easy bruising	Bleeding	Enlarged lymph nodes

Other: _____

Patient Signature: _____ Date: _____

Reviewed by: _____ MD Date: _____

BRIAN G. DICKSON, M.D. • SPENCER H. GUINN, M.D. • JEREMY P. SWYMN, M.D. • BRANDON M. BYRD, M.D.
1416 E. Matthews, Suite 200 • Jonesboro, AR 72401 • (870) 932-1820

SIGNATURE ON FILE

Patient's Name _____ Chart No._____

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment on all Medicare/Medicaid and/or other Health Insurance benefits to be reimbursed directly to Brian G. Dickson, M.D., Spencer H. Guinn, M.D., Jeremy P. Swymn, M.D., or Brandon M. Byrd, M.D. for services received by me or the above named patient on this date and until this authorization is revoked in writing by me. I understand that this authorization also allows for release of medical information required by my designated insurance company or their agent to determine the benefits payable, and that I am responsible for payment of all co-payments or deductibles as determined by my insurance carrier.

Signed _____ Date _____
(Insured or Authorized Person)

ASSIGNMENT OF FINANCIAL RESPONSIBILITY

I accept full responsibility for payment of all charges for services received by myself or the above named patient. I understand that payment of these charges are not contingent upon any third party agreements, settlement of a claim, or outstanding litigation.

Signed _____ Date _____
(Responsible Party)

AUTHORIZATION TO TREAT A MINOR

I authorize the above named Physician to provide such medical services including surgery, if necessary, as may be determined in the best interest to above name patient of which I am the parent or legal guardian. This authorization is effective this date and until revoked in writing by me.

Signed _____ Date _____
(Parent or Legal Guardian)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I would like to receive a copy of any amended Notice of Privacy Practices. Yes No (circle one)

Signed _____ Date _____

If not signed by the patient, please indicate relationship: ❑ Parent or guardian of minor patient
❑ Guardian or conservator of an incompetent patient ❑ Beneficiary or personal representative of deceased patient

For Office Use Only:
❑ Signed form received by: _____ ❑ Acknowledgment refused

Efforts to obtain: _____

Reasons for refusal: _____

Dickson Orthopedics, PA
DBA Jonesboro Orthopaedics and Sports Medicine

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have received a copy of the above named practice's
Patient Name

Notice of Privacy Practices.

_____ _____
Signature of Patient, Parent or Legal Guardian Date

Please PRINT below any family, friends, etc. that you would like to be able to give information to. These names will be added as contacts in our computer system and should anyone call requesting information, the list will be referenced and information will not be disclosed if the name is not indicated in the computer from your list below. The person that is listed as your emergency contact DOES NOT automatically get added to this list. If you would like them listed, please list them below.

NAME	RELATIONSHIP	CONTACT NUMBER

Signature _____ Date _____
(Patient, Parent or Legal Guardian)