JACKSON ORTHOPAEDIC CARE AND SURGERY

Patient Information

Name:_____ Date:_____ DOB:_____
First Middle Last MM/DD/YY MM/DD/YYYY

Address:_____

Mailing Address:_____

Home:_____ Cell:_____ Work:_____

Email Address:_____ Social Security #:_____

Gender:_____ Martial Status: ☐ ☐ ☐ ☐

Emergency Contact Name:_____

Relationship:_____ Contact #:_____

Occupation:_____ Employer:_____

Are you presently off work?_____ Last date worked:_____

Family Doctor:_____ Phone #:_____

Who referred you to our office?_____

Where you injured in an auto accident? _____ If yes, Auto Claim #:_____

Address of Auto Carrier:_____

Were you injured at work? _____ Date of Injury:_____

Was your injury due to slip and fall?_____ Date of Injury:_____

Did you file a claim? _____

Insurance Information

#1 Insurance

Insurance Carrier:_____

Name of Policy Holder:_____

Birthdate:_____

#2 Insurance

Insurance Carrier:_____

Name of Policy Holder:_____

Birthdate:_____

Copay:_____

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Describe the reason for your visit today. How did the symptoms first occur or injury happen?

Date of Injury: Where did the injury occur?_____

Check those that you have been treated for or have been told you have any of the following conditions.

- ☐ Alcoholism
- ☐ AIDS
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Cancer Type_____
- ☐ Chest Pain
- ☐ Colitis
- ☐ Colon Polyps
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Hepatitis Type_____
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Pneumonia
- ☐ Polio
- ☐ Gastric Reflux
- ☐ Rheumatoid Arthritis
- ☐ Sciatica
- ☐ Sleep Apnea
- ☐ Irritable Bowel Syndrome
- ☐ Stroke
- ☐ Ulcer
- ☐ Thyroid Disease
- ☐ Migraine

Present Height:_____ Present Weight:_____

JACKSON ORTHOPAEDIC CARE AND SURGERY

Surgery Performed	Year Performed
_____	_____
_____	_____
_____	_____
_____	_____

Medication Allergies	Reaction to Medication
_____	_____
_____	_____
_____	_____
_____	_____

List all medications you are taking currently

Name	Dosage	Frequency	State Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History of Medical History

Father	
Mother	
Brother(s)	
Sisters(s)	

Social History (Check all those that Apply)

- ☐ Smoking or Smoked a cigarette
- ☐ Use of Tobacco
- ☐ Drink Alcohol Amount: _____ Daily or Monthly
- ☐ Ever Use Smokeless Tobacco
- ☐ Use any recreational drug
- ☐ Drink Caffeine

Providing your signature below, you have completed this form to the best of your ability.

Signature:_____