Orthopaedic Associates of Marshall County

Dr. Joseph Kendra

Date: _____

Social Security Number: _____ - _____ - _____

Patient Name: _____ _____ - _____ - _____ _____

Last **First** **Middle Initial** **Date of Birth** **Age**

Mailing Address: _____ **City:** _____ **Zip:** _____

Street Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Patient Employer: _____ **Employer's Phone Number:** _____

□ Male □ Female **Race:** _____ **□ Non Hispanic □ Hispanic** **Language:** _____

Pharmacy: _____ **City:** _____

Email Address: _____

- **SPOUSE'S INFORMATION:**

Name: _____ **Social Security Number:** _____ - _____ - _____

Mailing Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Date of Birth: _____ - _____ - _____ **Employer:** _____

- **RESPONSIBLE PARTY (IF SOMEONE OTHER THAN PATIENT)** **Relation to Patient:** _____

Name: _____ **Social Security Number:** _____ - _____ - _____

Mailing Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Date of Birth: _____ - _____ - _____ **Employer:** _____

- **EMERGENCY CONTACT PERSON: (*Must have phone number different than patient*)**

Name: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____ **Date of Birth:** _____

- **METHOD OF PAYMENT: □ Cash □ Insurance □ Worker's Comp**

Is your visit related to employment / work-related injury? _____

PATIENT NAME: _____

- **PROBLEM YOU ARE HAVING TODAY / COMPLAINT: _____**

Date of Injury: _____

Referred by: _____ **Family Physician: _____**

- **MEDICAL HISTORY**

Please check the appropriate box.

Heart Disease: □ Yes □ No **Diabetes: □ Yes □ No** **Height: ____** ft **____** inches

Stroke: □ Yes □ No **Thyroid: □Yes □ No** **Weight: _____**

Ulcers: □ Yes □ No **High Blood Pressure: □ Yes □ No**

Blood Clots: □ Yes □ No

Cancer: □ Yes □ No If yes, what type? _____

Do you have a pacemaker? □ Yes □ No

Are you taking ANY blood thinners? □ Yes □ No If yes, what type? _____

Please list any other medical problems not listed above: _____

_____

Tobacco Use: □ Present User □ Former User □ Never Used

Do You Drink Alcoholic Beverages: □ Yes □ No If yes, □ Occasional □ Moderate □ Heavy

Have you ever had a fracture (broken bone?) □ Yes □ No

If yes, please list: _____

Have you ever had surgery? □ Yes □ No If yes, please list all surgeries: _____

_____

Are you allergic to any medications? □ Yes No □ If yes, please list _____

PATIENT NAME: _____

- **CURRENT MEDICATIONS:** Please list ALL medications you are currently taking and the dosage. Please include all prescription and over the counter medications.

☐ **CHECK HERE IF YOU TAKE NO PRESCRIPTION OR OVER THE COUNTER MEDICATIONS.**

MEDICATION	**DOSAGE (mg, etc.)**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Orthopaedic Associates' Notice of Privacy Practices. By signing below I am only giving acknowledgement that I have received or have had the opportunity to receive the Notice of Privacy Practices.

_____ _____

Patient Name (Printed) Date

Signature: _____

RELEASE OF INFORMATION AUTHORIZATION:

Due to federal privacy guidelines (HIPPA), Orthopaedic Associates is not allowed to divulge information to anyone other than the patient (or guardian of the patient) unless explicit written authorization is given to discuss personal medical information with someone other than you.

I, _____, give Orthopaedic Associates permission to release / discuss personal medical information to include the pickup of prescriptions and / or financial information to:

Name: _____Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Signature of Patient: _____ Date: _____

GUARANTEE OF ACCOUNT: MUST BE 19 YEARS OF AGE TO SIGN

I, the undersigned, directly assign to Orthopaedic Associates all surgical and / or medical benefits, if any, otherwise payable to me for services rendered.

In consideration of services rendered or to be rendered, the undersigned agrees to pay all costs of collection and / or reasonable attorney fees, should the account be turned over to enforce collections of said charges. The undersigned hereby waivers all claims or rights of exemption allowed by the constitution of the state of Alabama or any other state of the United States.

I hereby authorize Orthopaedic Associates to release any information necessary to secure payment of benefits to my account.

Signature: _____ Date: _____

May we leave voicemails on the numbers you've provided? □ Yes □ No

Comments: _____