



705 N 12th Street. – Middlesboro, KY 40965

PATIENT INFORMATION SHEET

DATE: _____ SOCIAL SECURITY#: _____ MARITAL STATUS: S M D W

NAME: _____ DATE OF BIRTH: _____ AGE: _____ SEX: M F

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

PATIENTS EMPLOYER: _____ OCCUPATION: _____

SPOUSES NAME: _____ SS# _____ DOB: _____

SPOUSES EMPLOYER: _____ PHONE: _____

IF PATIENT IS A MINOR, PLEASE LIST PARENT OR GUARDIAN

FATHER: _____ SS# _____ DOB _____

EMPLOYER: _____ PHONE: _____

MOTHER: _____ SS# _____ DOB _____

EMPLOYER: _____ PHONE: _____

SCHOOL: _____ FULL-TIME PART-TIME

NAME OF REFERRING PHYSICIAN: _____

REASON FOR VISIT: _____

HOW LONG HAVE YOU HAD THIS PROBLEM: _____

TYPE OF INSURANCE

- ANTHEM
- CHA
- BLUEGRASS
- UMWA
- MEDICARE
- MEDICAID
- WORKERS COMP
- AUTO
- OTHER (specify) _____

INSURANCE INFORMATION

THE NAME OF THE INSURANCE COMPANY, THE POLICYHOLDER AND THEIR RELATIONSHIP TO THE PATIENT.

NAME: _____

POLICYHOLDER: _____

RELATIONSHIP: _____

DATE OF ACCIDENT: _____

WAS ACCIDENT WORK RELATED? YES NO

WAS THIS AN AUTO ACCIDENT? YES NO

IF THIS IS A WORKERS COMP OR AUTO ACCIDENT, PLEASE GIVE THE

NAME OF YOUR ATTORNEY _____

PATIENT DIAGNOSTIC FORM

Name: _____

Date: _____

Chart #: _____

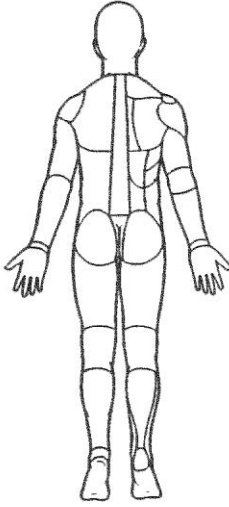
- | | Diagnosis Codes |
|---|------------------------|
| <input type="checkbox"/> Headaches | 784.0 |
| <input type="checkbox"/> Dizziness | 780.4 |
| <input type="checkbox"/> Neck Pain/Stiff | 723.1 |
| <input type="checkbox"/> Fainting | 780.2 |
| <input type="checkbox"/> Jaw Problems | 526.9 |
| <input type="checkbox"/> Nervousness | 799.21 |
| <input type="checkbox"/> Irritability | 799.22 |
| <input type="checkbox"/> Disorientated/Confused | 298.8 |
| <input type="checkbox"/> Bruises | See Contusions in ICD |
| <input type="checkbox"/> Light Headed | 780.4 |
| <input type="checkbox"/> Arm/Shoulder Pain | 719.41 |
| <input type="checkbox"/> Pins/ Needles Arms | 782.0 |
| <input type="checkbox"/> Pins/ Needles Legs | 782.0 |
| <input type="checkbox"/> Numbness/Tingling | 782.0 |
| <input type="checkbox"/> Difficulty Sleeping | 780.52 |
| <input type="checkbox"/> Chest Pain | 786.50 |
| <input type="checkbox"/> Shooting Pain Arms | 723.4 |

- | | Diagnosis Codes |
|---|------------------------|
| <input type="checkbox"/> Shooting Pain Legs | 724.4 |
| <input type="checkbox"/> Depression | 311 |
| <input type="checkbox"/> Leg Pain | 729.5 |
| <input type="checkbox"/> Memory Loss | 780.93 |
| <input type="checkbox"/> Ears Ringing | 388.30 |
| <input type="checkbox"/> Loss of Balance | 780.4 |
| <input type="checkbox"/> Blurred Vision | 368.8 |
| <input type="checkbox"/> Pain behind Eyes | 379.91 |
| <input type="checkbox"/> Fatigue | 780.79 |
| <input type="checkbox"/> Pain in Buttocks | 724.3 |
| <input type="checkbox"/> Broken Bones | See IX in ICD book |
| <input type="checkbox"/> Upper Back Pain | 724.1 |
| <input type="checkbox"/> Low Back Pain | 724.2 |
| <input type="checkbox"/> Mid Back Pain | 724.1 |
| <input type="checkbox"/> Muscle Spasms | 728.85 |
| <input type="checkbox"/> Muscle Weakness | 728.87 |
| <input type="checkbox"/> Muscle Cramps | 729.82 |

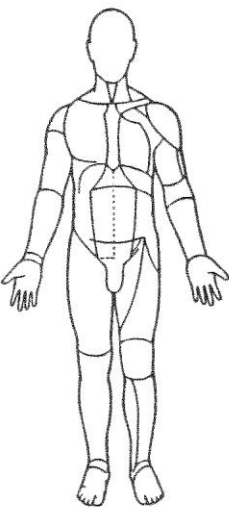
Any problems or symptoms not listed: _____

What is your chief complaint? _____

Please draw on the diagrams below where the pain is located.



Back



Front

What caused this problem? _____

What relieves the pain? _____

What other doctors have you seen for this problem?

What tests or studies have you had for this problem and the results (*MRI, CT, NERVE, X-RAYS, SURGERY, ETC.*)

PATIENT MEDICAL HISTORY

NAME: _____ FAMILY PHYSICIAN: _____

LIST ALL MEDICATIONS YOU ARE ALLERGIC TO: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

LIST ALL MAJOR OPERATIONS IN THE LAST 10 YEARS: _____

HEIGHT: _____ WEIGHT: _____

PLEASE MARK ANY OF THE FOLLOWING ILLNESSES THAT EFFECT YOU AND GIVE SPECIFICS

- | | |
|---|--|
| <input type="checkbox"/> HYPERTENSION _____ | <input type="checkbox"/> LUNG DISEASE _____ |
| <input type="checkbox"/> ANGINA _____ | <input type="checkbox"/> HEART DISEASE _____ |
| <input type="checkbox"/> DIABETES _____ | <input type="checkbox"/> KIDNEY DISEASE _____ |
| <input type="checkbox"/> CANCER _____ | <input type="checkbox"/> THYROID DISEASE _____ |
| <input type="checkbox"/> TUBERCULOSIS _____ | <input type="checkbox"/> OTHER _____ |

IN CASE OF EMERGENCY, PLEASE NOTIFY THE FOLLOWING INDIVIDUAL(S)

NAME: _____

ADDRESS: _____

RELATIONSHIP TO PATIENT: _____ PHONE # _____

NEAREST RELATIVE NOT LIVING WITH YOU: _____

RELATIONSHIP TO PATIENT: _____ 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 if under 18, Parent 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 if under 18, Parent or Legal Guardian Date