JEFFERSON ORTHOPEDIC CLINIC **Patient Registration Form**

Mark Juneau, Jr., M.D.
Matthew R. Grimm, M.D.

Wesley A. Clark, M.D.
Barton L. Wax, M.D.

Scott A. Tucker, M.D.
John M. Kesler, PA-C

Today's Date: _____ / _____ / ______

Preferred Doctor: Dr. Juneau ☐ Dr. Grimm ☐ Dr. Clark ☐ Dr. Wax ☐ Dr. Tucker ☐ John Kesler ☐

Preferred Pharmacy: Name: ________________________ Phone # _______________ Fax # _______________

Pharmacy Adress: ____

Patient:
Last Name: ________________________ **First:** ________________________ **M.I.** __________

Preferred Name: ________________________ **Maiden Name**: ________________

Date of Birth: _____ / _____ / ______ **Sex:** M F Other **SSN:** _________ - _______ - __________

Race: American Indian ○ Asian ○ Black–African American ○ National Hawaiian Pacific Islander ○ White ○ Other Race ○

Marital Status: Annulled ○ Common Law ○ Domestic Partner ○ Interlocutory ○ Legally Separated ○

Register Domestic Partner ○ Single ○ Married ○ Unmarried ○ Widowed ○

Drivers License# __________________ **State:** ________________

Primary Languange: Arabic ○ Chinese ○ English ○ Filipino ○ French ○ German ○ Greek ○ Hindi ○ Italian ○ Japanese ○

Korean ○ Other ○ Polish ○ Portuguese ○ Russian ○ Spanish ○ Vietnamese ○

Religion: Buddhist ○ Catholic ○ Hindu ○ Islam ○ Jewish ○ Other ○ Protestant ○ Unknown ○

Ethnicity: Hispanic or Latino ○ Not Hispanic or Latino ○ Declined ○ Unknown ○

Home Street Address: ____

City: ________________________________ **Parish:** _______________ **State:** ________ **Zip**: _________

Country: United States ○ Canada ○ Mexico ○ Unknown ○ Other ○ _______________

Phone: Home#: ______________ Primary Work#:___________

Cell#: _______________ Primary Contact#:___________

Fax#: _______________ EMAIL:_______________________________

Preferred Communication: Home# ○ Primary Work# ○ Cell# ○ Fax# ○ Email ○ Mail ○ Patient Portal ○

Are You Employed: Yes ○ No ○ Full ○ Part-Time ○ **Are you a student:** Yes ○ No ○ Full Time ○ Part-time ○

Reason for visit: ____

Work Accident Accident Sports Injury Recurring Illness Other

If an accident, Date of Accident: _____ / _____ / ______ **Place of accident:** _________________________________

Did you go to the hospital? Yes ○ No ○ If Yes, What Hospital did you go to: _________________________

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Employer (or Parents Employer)

Name of Company: ______________________________ Work Phone ________________________

Occupation: ____

Address: ____

City: ___________________________________ State: ____________________ Zip: ______________

Emergency Contact (Friend or Relative not living with you)

Name of Contact: ______________________________ Phone/ Cell / Pager (_____)_______________

Your relationship to emergency contact: ____

Spouse Information

Spouse's Name: ________________________________ Phone / Pager: _________________________

Employer: _____________________________________ Work Phone: ___________________________

Insurance Information (Give insurance card and Drivers License to receptionist)

Insured Name: ____

Primary Insurance: ___________________________ Policy or ID#: ______________________________

Mailing address: _____________________________ City: ________________ State _______ Zip _______

Name of Insured: ____________________________ Group Name: ______________ Group# ___________

Secondary Insurance Information (Give insurance card to receptionist)

Secondary Insurance: ___________________________ Policy or ID#:_____________________________

Mailing address: _____________________________ City:________________ State _______ Zip _______

Name of Insured: ____________________________ Group Name: ______________ Group# ___________

CONSENT FOR TREATMENT: I as a patient consent to medical care including examination, diagnostic, or surgical treatment by the treating physician and such associates or assistants as may be deemed necessary. I am aware that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of any treatment.

Patient Signature:________________________________ **Date:** ______/_______/________

AUTHORIZED RELEASE OF INFORMATION: I hereby authorize Jefferson Orthopedic Clinic to release those medical records pertaining to my treatment to any entity that is responsible for payment of physician charges. I understand that this authorizes my insurance company to pay any benefits directly to Jefferson Orthopedic Clinic. In addition, I further understand that I am ultimately responsible for charges incurred for services rendered, and that collection fees will be added to balance not paid in a timely manner.

Patient Signature: ________________________________**Date:** _____/_______/_________

JEFFERSON ORTHOPEDIC CLINIC
Patient Medical History

Any questions left blank will be considered not to be a problem or a “negative response”.

Office Use Only: Height:__________ Weight__________ Sex: M / F
B/P _______/_________Heart Rate: _______ Date: / /

Patient Name: ____

Referring Physician: ____
Referring Physician Address: ____
Referring Physician Phone: ____

CHIEF COMPLAINT: Why are you seeing the doctor today?
………

Injured Body Part: Check: Neck☐ Shoulder☐ Back☐ Arm☐ Hand☐ Elbow☐ Hip☐ Knee☐
Leg☐ Ankle☐ Foot☐ Other:☐ ________________________________
Date of Incident: _________________

Your Current Medical Problem is the result of:
- ☐ Car Accident
- ☐ Work Accident
- ☐ Accident
- ☐ Sport Injury
- ☐ Other: ______________________

This occurred during:
- ☐ Lifting
- ☐ Pulling
- ☐ Running
- ☐ Twisting
- ☐ Falling
- ☐ Bending
- ☐ Squatting
- ☐ Reaching
- ☐ Hit by Object
- ☐ Other: ___________

HISTORY OF PRESENT ILLNESS:
………

Rate your *Pain or Discomfort* using this scale Choose:
None= 0◯ 1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯ =Severe

How long does your *Pain or Discomfort* last?: (seconds, minutes, hours, etc...) ______________________
For what period of time has this problem existed?: (days, weeks, months, years) ____________________

Describe it. Check all that apply: Sharp☐ Dull☐ Burning☐ Throbbing☐ Electric Shock☐
Tingling☐ Numbness☐ Swelling☐ Locking☐ Popping☐ Giving Way☐ Catching☐ Stiffness☐

When does your Pain and Discomfort occur? Check all that apply:
Walking☐ Standing☐ Rising From Chair☐ During Exercise☐ After Exercise☐ Running☐
Going Up Stairs☐ Going Down Stairs☐ At Work☐ After Work☐ At Night☐ When Asleep☐
Other:☐ ____

What makes your Pain or Discomfort better: Check all that apply:
Rest☐ Therapy☐ Medication☐ Heat☐ Cold☐ Exercise☐ Brace☐ Bandage☐
Other: ☐ ____

Have you had any other treatment for this problem? Choose: Yes◯ NO◯ If YES explain by who, when & where? ____

Have you had any X-rays, (Check) MRI’s☐ CT Scans☐ Bones Scans☐ Blood or Lab work☐ in the past for this problem? Choose: Yes◯ NO◯ If YES , Where and When were these tests performed? ____

JEFFERSON ORTHOPEDIC CLINIC
Patient Medical History

Patient Name: ____

MEDICATION ALLERGIES: Please list:

CURRENT MEDICATION (If you do not know how to spell the medication please inform the nurse when seen)

MEDICATION: ________________________ **DOSE:** _____________ **HOW LONG:** ______________

MEDICATION: ________________________ **DOSE:** _____________ **HOW LONG:** ______________

MEDICATION: ________________________ **DOSE:** _____________ **HOW LONG:** ______________

MEDICATION: ________________________ **DOSE:** _____________ **HOW LONG:** ______________

MEDICATION: ________________________ **DOSE:** _____________ **HOW LONG:** ______________

MEDICATION: ________________________ **DOSE:** _____________ **HOW LONG:** ______________

MEDICATION: ________________________ **DOSE:** _____________ **HOW LONG:** ______________

MEDICATION: ________________________ **DOSE:** _____________ **HOW LONG:** ______________

JEFFERSON ORTHOPEDIC CLINIC
Review of Systems

Any questions left blank will be considered not to be a problem or a "negative response".

Are you currently or have you had problems with your: If any are checked YES please explain.

Circle

Yes ○ No ○ Cardiovascular: (Blood Pressure, Chest Pain)________________________
Yes ○ No ○ Arthritis: (Rheumatoid, Osteoarthritis)________________________
Yes ○ No ○ Neurologic: (Numbness, Tingling, Balance)________________________
Yes ○ No ○ Constitutional: (Weight Loss, Diet, Development)________________________
Yes ○ No ○ Stomach Ulcers: ________________________
Yes ○ No ○ Diabetes: ________________________
Yes ○ No ○ Liver Disease: ________________________
Yes ○ No ○ Blood Clots: ________________________
Yes ○ No ○ Disabled: (How & When)________________________

PAST MEDICAL HISTORY: Please indicate any major surgeries or hospitalizations, and if there were complications.

Hospitalizations/ Surgeries (type)/ Major Injuries	Year	Complications (if any)
________________	______	________________
________________	______	________________
________________	______	________________
________________	______	________________

Have you ever had general anesthesia (put to sleep) Yes ○ No ○ If YES, Were there any problems:
Yes ○ No ○ If Yes, please explain the problem: ________________________

FAMILY HISTORY: Please complete to the best of your knowledge.

	Alive	Deceased	If deceased, cause of death	Health Status		
Mother	○	○	________________	Good ○	Poor ○	Excellent ○
Father	○	○	________________	Good ○	Poor ○	Excellent ○
Sister/Brother	○	○	________________	Good ○	Poor ○	Excellent ○
Children	○	○	________________	Good ○	Poor ○	Excellent ○

SOCIAL HISTORY: Please answer all questions.

Are you Employed? Yes○ No ○ If Yes, Occupation: ________________________
Marital Status: Single○ Married○ Separated○ Widowed○
Do you have children: Yes○ No○ Do you live with: Spouse○ Relatives○ Alone○ Other○
Do you exercise: Yes○ No○ If yes, what type or kind of exercise? ________________________
Are you on any kind of special diet? Yes○ No○ If yes, What type or kind: ________________________
Have you had history of substance abuse? Yes○ No○ If yes, Explain: ________________________
Do you smoke? Yes○ No○ If yes, How long have you smoked?: ____________ How many packs Per Day? ____________
Do you drink alcohol? Yes○ No○ If yes, How much? ____________ How Long: ____________
Education: Check: Jr. High School○ GED○ High School○ College○ Graduate School○ Other: ____________

Physicians Initials:________________________ Date:____________

PFSH + ROS Updated:
Updated:____________Int:_____/ Updated:____________Int:_______/ Updated__________Int:____________

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

HIPAA

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Jefferson Orthopedic Clinic's 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 our Privacy Practices.

____ ________________________

Patient Name (Type or Print) Date

____

Signature