# HOT SPRINGS BONE AND JOINT CLINIC, P.A.

PLEASE PRINT

Chart No.___________

1) Patient's full name_____________________________________ Age_____ Birthday __________

Address ___________________________ City_______________State_______ Zip__________

Home phone___________________________ Cell________________________________

Male ___ Female ___ Married ____ Single _____ Social Security No. ____ ___ ____

Name of friend at different address and their telephone number:

______________________________________________________________________________

Financially responsible party (If other than patient)______________________________

(If a minor please note the person bringing the patient to the appointment is responsible for the co-pay at the time of visit.)

Occupation________________________________Employer_____________________________

Address___________________________________Phone _______________________________

Spouse's employer/occupation_________________Phone_______________________________

2) Reason for visit __________________________________________________________________

1) Was this an injury? ___Yes ___ No Motor vehicle accident ___Yes___No

2) Date of injury ____________ Is this a Workers comp Injury? ___Yes___No

3) Where and how injury happened ____________________________________________________

____________________________________________________________________________

4) Previous treatment _____________________________________________________________

Family physician______________ Who referred you to our office?_______________________

3) Primary Insurance_____________________ Subscriber's Name__________________________

Policy/ID No. ________________________ Group No. _________________________________

Date of birth_________________________ Social Security No.__________________________

Secondary Insurance__________________ Subscriber's Name__________________________

Policy/ID No. ________________________ Group No. _________________________________

4) Past Medical History (List any serious illness, injuries, operations, or pertinent family history.)

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

5) Please list all medications taken regularly.

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

6) Allergies ________________________________________________________________

7) Do you take Coumadin or Plavix? ____Yes ____No

8) Please check all that apply to your medical history:

| | | |
|---|---|---|
| ___High Blood Pressure | ___Headaches | ___Diabetes |
| ___Shortness of Breath | ___Kidney Problems | ___Heart Palpitations |
| ___Heart Problems | ___Chest Pain | ___Liver Problems |
| ___Dizziness | ___Cancer | ___Pneumonia |
| ___Anemia | ___Prostate Disease | ___Thyroid Problems |
| ___Bladder Problems | ___Ulcers | ___Frequent Infections |
| ___Asthma | ___Hepatitis | ___Gout |
| ___Nervousness | ___Circulation Problems | ___Depression |
| ___Arthritis | ___Rheumatic Fever | ___Hysterectomy |
| ___Bleeding Disorder | ___HIV | ___Latex Allergy |

Date Reviewed:____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____