Name:
DOB:
Chart:
Age:
Date:

West Tennessee Bone & Joint Clinic, P.C.

24 Physicians Drive ● Jackson, Tennessee
Phone 731-661-9825
Fax 731-668-6757

Patient Information

DATE

MEDICAL RECORD #		
AGE	SEX	RACE

1

ALLERGIES (Please List)			
REFERRED BY: (Dr's name, Friend's name, Phone book)			
PATIENT'S LAST NAME	FIRST NAME		MIDDLE NAME
ADDRESS	CITY	ST	ZIP

HOME PHONE	WORK PHONE	DATE OF BIRTH	SOCIAL SECURITY #	MARITAL ST
CELL PHONE	EMAIL	EMPLOYER NAME & PHONE NUMBER		OCCUPATION
SPOUSE'S NAME		SPOUSE'S EMPLOYER NAME & PHONE NUMBER		

2

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING

FATHER'S NAME		MOTHER'S NAME	
ADDRESS		ADDRESS	
SS #	BIRTHDATE	SS #	BIRTHDATE
HOME #	WORK #	HOME #	WORK #
EMPLOYER		EMPLOYER	
OCCUPATION	HOW LONG?	OCCUPATION	HOW LONG?

****WORK RELATED INJURIES REQUIRE PRIOR APPROVAL****

3

REASON FOR TODAY'S VISIT			
Was this an injury? ☐ YES ☐ NO	Date of Injury or Onset	Work Related? ☐ YES ☐ NO	Sports Related Injury If yes, School Name/Phone ☐ YES ☐ NO
DESCRIBE HOW INJURY HAPPENED			

4

PRIMARY INSURANCE #1 NAME		POLICY HOLDER'S NAME	
COMPLETE ADDRESS (Usually located on back of card)		POLICY HOLDER'S DATE OF BIRTH	
POLICY OR CONTRACT #	GROUP #	RELATIONSHIP OF POLICY HOLDER TO PATIENT	OFFICE CO-PAY AMOUNT

Name:
DOB:
Chart:
Age:
Date:

5

SECONDARY INSURANCE #2 NAME		POLICY HOLDER'S NAME	
COMPLETE ADDRESS (Usually located on back of card)			
POLICY OR CONTRACT #	GROUP #	RELATIONSHIP OF POLICY HOLDER TO PATIENT	OFFICE CO-PAY AMOUNT

Preferred Pharmacy _____ Phone _____

Address _____

In case of Emergency, Notify _____ Phone _____

DEMOGRAPHICS (choose the best description)

RACE CHOICES: ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Type-Unknown

ETHNICITY CHOICES: ☐ Hispanic Origin ☐ Non-Hispanic ☐ Type-Unknown

LANGUAGE CHOICES: ☐ Chinese ☐ English ☐ Japanese ☐ Portuguese ☐ Spanish ☐ Other _____

6

PLEASE SIGN BELOW, IF YOU HAVE ANY QUESTIONS, PLEASE SEE RECEPTIONIST IN OFFICE

CONSENT FOR MEDICAL TREATMENT

I authorize West Tennessee Bone & Joint Clinic physicians and personnel to render medical treatment and evaluation needed. I further authorize order of x-rays, injections, casting or other diagnostic tests and treatment that may be necessary.

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I understand that I have rights regarding my protected health information. These rights are governed by the Health Insurance Portability and Accountability Act of 1996. (HIPAA) I have been informed, and given the opportunity to review and secure a copy of the Clinic's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information.

I hereby authorize the release and disclosure of my protected health information for treatment, payment or health care operations. I understand that any and all records concerning my personal and medical history are the confidential property of West Tennessee Bone & Joint Clinic, P.C.

I agree that West Tennessee Bone & Joint Clinic may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

You may restrict the individuals or organizations to which your health care information is released and you may revoke your authorization to us at any time, however, your revocation must be in writing and delivered to our address.

CONSENT FOR FINANCIAL RESPONSIBILITY

I acknowledge full financial responsibility for services rendered by West Tennessee Bone & Joint Clinic, P.C. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements are made prior to treatment. I agree to pay all collection and attorney fees, if applicable, in the event of default of payment of my charges. I assign benefits to and authorize direct payment to West Tennessee Bone & Joint Clinic of which it is entitled. This also includes proceeds and benefits accruing under any settlement, structure or otherwise, or awarded in judgment for personal injuries caused by a third party. I agree to pay for all charges not paid pursuant to this agreement.

X _____ _____

Signature of Patient or Responsible Party Date

(must be 18 years of age or older to sign)

IF YOU HAVE ANY QUESTIONS ABOUT THIS FORM, PLEASE ASK THE RECEPTIONIST. BRING COMPLETED FORMS ALONG WITH PHOTO IDENTIFICATION AND CURRENT INSURANCE CARDS TO THE RECEPTIONIST. THIS PROCEDURE IS FOR YOUR PROTECTION AGAINST ABUSE TO YOUR INSURANCE.

Name:
DOB:
Chart:
Age:
Date:

NEW PATIENT / HISTORY SHEET

HISTORY BY PHONE **REVIEWED ON:**_____ **BY:**_____

NAME:			**DATE:**	
ID #:	**DOB:**		**DATE OF ONSET:**	
Occupation:	School:		**REHAB/NH:**	
Age: Sex:	Handedness: ☐ RT ☐ LT		Ht:	Wt:
Medical Doctor:	Referring Physician:			
Marital Status: ☐ S ☐ M ☐ D ☐ W	Race: ☐ B ☐ W Other:			

Smoke: ☐ Current every day smoker ☐ Current some day smoker ☐ Smoker, current status unknown
☐ Never smoker ☐ Former smoker ☐ Unknown if ever smoked

Drink Alcohol? ☐ Y ☐ N AMT.

Do you use drugs for recreational use? ☐ Y ☐ N AMT. What kind?

PAST MEDICAL HISTORY	☐ **NONE**	☐ High Cholesterol	☐ Sleep Apnea
☐ Diabetes	☐ Stomach Ulcers	☐ Reflux	☐ Asthma
☐ Stroke	☐ Heart Attack	☐ Heart Disease	☐ Bleeding Disorders
☐ High Blood Pressure	☐ Blood Clots	☐ Nervous Disorder	☐ Thyroid Disorder
☐ Cancer	☐ Kidney Disorder	☐ Arthritis	☐ Gout
☐ Hepatitis	☐ Other:		

SURGERIES

MEDICATIONS ☐ **NONE** ☐ **(SEE LIST)** ☐ **COUMADIN** ☐ **PLAVIX** ☐ **ASPIRIN**

ALLERGIES/REACTIONS	☐ **FLOWSHEET**	☐ **NKDA**	☐ **LATEX**	☐ **TAPE**	☐ **IODINE/BETADINE**
☐ PCN:	☐ Demerol:		☐ Aspirin:		
☐ Sulfa:	☐ Codeine:		☐ Non Steroidal Anti-Inflammatory Drugs:		
☐ Mycins:	☐ Other:				

SERIOUS INJURIES: ☐ **NONE**

RECENT ILLNESS: ☐ **NONE** ☐ **HOSPITALIZATION**

REVIEW OF SYSTEMS ☐ **NONE**

☐ Chest pain/Palpitations	☐ Unintentional Weight Loss	☐ Psychological Problems
☐ Difficulty Sleeping or Excessive Fatigue	☐ Eye Problems	☐ Joint/Limb Pain
☐ Loss of Appetite	☐ Ears, Nose, or Throat	☐ Rash/Lesions
☐ Shortness of Breath	☐ Bleeding Problems	☐ Other _____
☐ Change in bowel habits	☐ Balance Problems	
☐ Change in bladder habits	☐ Numbness/Tingling	

FAMILY HISTORY	☐ **NONE**				
☐ Heart Disease	☐ High Blood Pressure	☐ Cancer	☐ Stroke	☐ Bleeding Disorder	☐ Arthritis
☐ Diabetes	☐ Other:				

CHIEF COMPLAINT:

Name:
DOB:
Chart:
Age:
Date:

WEST TENNESSEE BONE & JOINT
Sports Medicine • Orthopedic Excellence

ADDITIONAL CONSENT FOR DISCLOSURE OF MEDICAL INFORMATION

West Tennessee Bone & Joint Clinic, P.C. realizes you may wish to have a family member or close friend present at times when health information is discussed with you, such as the time of your office visit, prior to and after surgery, discussing test results etc.

We realize the importance of protecting your privacy. This authorization gives the above Clinic and Staff your consent to disclose personal health information about you to your family, close personal friends, or any person that you identify, as long as the information disclosed to those individuals is relevant to the involvement in your treatment, payment or healthcare operations. The above listed Clinic may notify a family member or another person who is responsible for your care of your location and general health condition.

This form also provides you with the opportunity to choose not to have your health information disclosed to individuals in your care. You must return this form if you wish to opt-out of such disclosures.

Please initial one of the following to indicate your choice regarding such disclosures:

_____ **I do not object** to my personal health information being disclosed to a family member, friend, or another individual (et al., physician, trainer, therapist, case manager) involved in my care.

_____ **I object** to my personal health information being disclosed to a family member, friend, or another individual involved in my care.

_____ _____

Signature of Patient or Guardian
(Must be 18 years of age or Older to sign)

Date