

TUCKER ORTHOPEDICS

Specialists in Joint Disorders & Surgery

***THIS INFORMATION IS VERY IMPORTANT AND HELPS US SERVE YOU BETTER.
THANK YOU FOR YOUR TIME IN FULLY COMPLETING THE FORM***

Name: _____ Age: _____

Your Family Doctor or Internist: _____

May we send our findings to your family doctor? **YES NO**

What are you seeing us for today: Left Right
 shoulder elbow wrist hand hip knee ankle foot neck back other _____

If for an injury, circle one or more: motor vehicle workers' comp home sports other _____

Date of injury: ____/____/____. **Do you have an attorney:** Yes No Name: _____

If this was a work accident, have you filed a claim? **Yes No** If yes, was your claim accepted? **Yes No**
 If your claim was denied, are you trying to have it accepted? **Yes No**

Past Medical History: (please check all that apply)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> HIV	<input type="checkbox"/> AIDS
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer /Type:	<input type="checkbox"/> Hepatitis / type: A B C other	<input type="checkbox"/> Other List:
<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Ulcers	
<input type="checkbox"/> Recurrent Infections	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Reflux	

Are you allergic to? : Tape Iodine/Shellfish IVP dye Penicillin Latex Other
 (please list)

I HAVE NO KNOWN ALLERGIES: _____

CURRENT MEDICATIONS: (List Medication and Dosage)

Medication	dosage
1.	
2.	
3.	
4.	
5.	
6.	
7.	

(If you are on more than seven medications, please give the list to the staff and we will attach a copy for your chart.)

_____ Medication list copied. See attached medication list.

Patient and Insurance Information (cont'd)

Name: _____

PAST SURGICAL PROCEDURES: (Please list all)

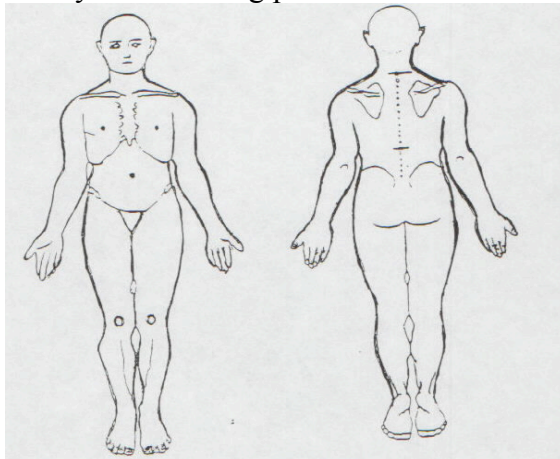
Do you smoke now? **Yes No** How many packs per day? _____)

Did you ever smoke **Yes No** If yes, when did you quit? _____

Do you drink alcohol? **Yes No** (___ daily ___ weekly ___ socially ___ rarely)

Do you or have you ever used recreational drugs? (example: marijuana, cocaine, heroin, etc.)
___ NO ___ YES (list: _____)

Please indicate on the diagram where you are having pain. Please draw or circle to best describe your pain.



Yes No Did you gain or lose a significant amount of weight in the past few months? Amount _____ lbs

Yes No Do you experience shortness of breath? How often? _____

Yes No Do you have GERD, an ulcer, or reflux?

Yes No Do you experience chest pain? ___ daily ___ occasionally ___ rarely

Yes No Do you have bowel or bladder problems? list: _____

Yes No Are you hard of hearing?

Yes No Do you wear glasses or contacts?

Yes No Do you have ___ capped teeth ___ dentures ___ crown/s?

What is your current weight? _____ height? _____

Is there any other medical information that you would like to share with the physician? ___ No ___ Yes
(Please describe, briefly)

Patient and Insurance Information (cont'd)

Name: _____

Marital Status: M S W D Age: _____ Date of Birth _____ Gender: M F

Home Address: _____

City: _____ State: _____ Zip code: _____

Telephone: Home: _____ Cell: _____ Work: _____

E-Mail address: _____

Social Security #: _____ - _____ - _____

Employer: _____

Employer Address: _____

Employer Telephone: (____) _____ - _____ ext: _____

PRIMARY Medical Insurance Name:

Subscriber for Primary Medical Insurance: _____

Relationship to Subscriber: _____

PRIMARY Medical Insurance Address: _____

PRIMARY Medical Insurance Phone Number: (____) _____ - _____

PRIMARY Medical Insurance Policy Number: _____

Group Number: _____

SECONDARY Medical Insurance Name:

Subscriber for Secondary Medical Insurance: _____

Relationship to Subscriber: _____

Secondary Medical Insurance Address: _____

Secondary Medical Insurance Phone Number: (____) _____ - _____

Secondary Medical Insurance Policy Number: _____

Group Number: _____

WORKERS' COMPENSATION

Date of Injury: _____

Compensation Claim Number: _____

Compensation Insurance Company: _____

Compensation Insurance Company Address: _____

Compensation Carrier Phone Number: (____) _____ - _____

Compensation Carrier Contact Person: _____ Phone: (____) _____ - _____

Patient and Insurance Information (cont'd)

Emergency Contact: _____ Phone: (_____) _____ - _____

Relationship to Patient: _____

Name of person that you authorize to obtain/receive your medical information:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Patient/Guardian Signature: _____ Date: _____

Release of Medical Information

I request that payment of authorized Medicare/Other insurance benefits be made on my behalf to **Tucker Orthopedics** for any services furnished me by physician or supplier. I authorize release of medical related information to the Center for Medicare and Medicaid Services and/or my insurance company and its agents, and any information needed to determine these benefits/benefits payable for related services. I am responsible for all charges, regardless of insurance status, as well as co-payments, co-insurance, and any deductibles.

Patient / Guardian Signature: _____ Date: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: (_____) _____ - _____

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Acknowledgement and receipt of Notice of Privacy Practices

I, _____ (print name) hereby acknowledge that on

The date set forth below, I have reviewed Tucker Orthopedics Notice of Privacy Practices.

Date: _____

Signature: _____
(Patient or Representative)

If signed by someone other than the patient, please state your legal relationship to the patient. _____

For more information about your privacy rights, please see our "Notice of Privacy Practices" available on our website at www.tuckerorthopedics.com.

Efforts to obtain signature on acknowledgement of notice form (choose one)

_____ Patient or Personal Representative was asked to sign form and refused.

_____ Other (explain)

Signature of office personnel

Date

Printed name

ELECTRONIC MEDICATION HISTORY CONSENT

Printed Name: _____

I allow Jon B Tucker MD, PC to download my E-Med electronic medication history.

Signed: _____

Date: _____