JACKSON ORTHOPAEDICS

HAND • WRIST • ELBOW • SHOULDER

Welcome to Jackson Orthopaedics. To ensure a proper diagnosis and treatment, we ask that you complete these pages of information. We have designed them to be as quick and painless as possible while still obtaining all the pertinent facts. You may print them out and bring with you to your appointment; for privacy reasons, we ask that you not email these back to our office.

Patient Name_______________________________ DOB____/____/_____ Age__________ Female ☐ Male ☐

Cell Phone___________________ Other Phone_____________________ SSN_____-_____-_____

Email: ____ Marital Status_____________

Address____City_____________________State_______Zip_________

If Minor – Mother Name: ______________________________ Father Name: _______________________________

Emergency Contact____Phone____________________________

Preferred Language: _________________________

Referring Physician_________________________________ Phone_______________________________________

Primary Care Physician______________________________ Phone_______________________________________

Preferred Pharmacy Name & Location_______________________________Phone___________________________

Primary Insurance Name____

Secondary Insurance Company (if any)____

IF INSURED IS SOMEONE OTHER THAN PATIENT (spouse, parent, etc.), PLEASE COMPLETE:

Insured Name _______________________________ Phone_________________________________

Relationship to patient__________________ DOB____/____/____ SSN______-_______-_______

Work Related Information (for Workers' Compensation Injuries Only)

PLEASE NOTIFY RECEPTIONIST IF WORKERS' COMP TODAY

Employer___________________________Phone________________________Date of injury___________

Address____________________________City___________________State_________Zip______________

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Name:____

Preferred Name:_________________

Occupation: ________________________________ Employer: ________________________________

Hand Dominance: ☐ Right ☐ Left ☐ Ambidextrous

Is this a work-related complaint: ☐ No ☐ Yes

Chief Complaint: ____

Date of injury and/or when you first noticed the problem____

If you had an injury, how did the injury occur____

Location of problem or injury

Right ☐ Shoulder ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Thumb ☐ Finger___________ (specify finger(s))

Left ☐ Shoulder ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Thumb ☐ Finger___________ (specify finger(s))

How would you describe symptoms?

☐ Pain ☐ Numbness ☐ Tingling ☐ Popping ☐ Locking ☐ Stiffness ☐ _____________________

Describe the quality of your pain?

☐ Sharp ☐ Dull ☐ Ache ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ ________________

Severity of pain? ______ (0-10, 0=no pain, 10 = most intense pain ever experienced)

Frequency of symptoms?

☐ Rarely ☐ Sometimes ☐ Off & On ☐ Often ☐ Constantly

Symptoms occur most commonly?

☐ In the morning ☐ During the day ☐ At night ☐ Equally throughout a day

What makes your symptoms worse?

☐ Increased activity/exercise ☐ Gripping/squeezing ☐ Overhead activity ☐ ___________________________

Treatments have you tried?

☐ Nothing ☐ Rest ☐ Stretching ☐ Splint/Brace ☐ Heat ☐ Ice ☐ Steroid Injection ☐ Surgery ☐ Therapy

☐ Medication/NSAIDs ____________ ☐ Other medical provider _____________________

What treatment has improved symptoms ______________________

Alcohol use:

❒ Do not drink ❒ Occasional drink ❒ Frequently drink ❒ Daily drink ❒ History of alcoholism

Do you use tobacco products?

❒ Never ❒ Not now. I quit ______. ❒ Yes: ___packs per day. Used for ___years. ❒ Smokeless tobacco

Do you use controlled or illegal substances?

❒ Never ❒ Not now. I quit______. ❒ Yes: ________________(type)

Do you have any ALLERGIES? ☐ No known allergies ☐ Yes (list below)

____

____

____

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Medications:

Medications/Dose (including OTC & Vitamins)	Medications Cont.

SURGICAL History and Illness: Please list below, including year and any complications:

Surgery	Illness/Hospitalizations

MEDICAL and family history: (CHECK all that apply)

	SELF	Family	Family Relation		SELF	Family	Family Relation
Anemia				Heart Murmur			
Asthma				Hepatitis			
Blood Clots				High Blood Pressure			
Cancer				HIV			
Coronary Artery Disease				Hypothroidism			
COPD				Osteomyelitis			
Depression				Osteoarthritis			
Diabetes				Psoriasis			
Gout				Rheumatoid Arthritis			
Heart Attack				Stroke			
Heart Failure				Tuberculosis			

Other Medical History: ____________________

____

Review Of Symptoms: Do you have any trouble with any of the following?

- ☐ Headache ☐ Eyesight ☐ Hearing ☐ Chest Pain ☐ Swallowing ☐ Rashes
- ☐ Diarrhea ☐ Constipation ☐ Poor Circulation ☐ Blood in Stool ☐ Night Sweats ☐ Weight Loss
- ☐ Ulcers ☐ Balance ☐ Leg Swelling ☐ Shortness of Breath ☐ Painful Urination

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Terms of Agreement and Assignment of Insurance Benefits

Records: R. Brent Jackson, D.O., P.A., is authorized to release or request confidential medical information to or from other parties involved in my care including my insurance carrier, my referring physician and/or my primary physician.

Financial Agreement: Payment is due at time of service unless prior arrangements have been made. I hereby direct assignment of payment of medical benefits to R. Brent Jackson, D.O., P.A. for services rendered. Accordingly, I accept full financial responsibility for all items or services, which are determined by the health care service plan not to be covered or applied to a copay, coinsurance or deductible.

Insurance Participation: R. Brent Jackson, D.O., P.A. will file a claim with your primary/secondary insurance carrier on your behalf. We will not, however, become involved in any disputes you may have with your insurance carrier. The practice does not bill to any third party (e.g. school or auto insurance).

Payment for Services: R. Brent Jackson, D.O., P.A. accepts payment for services by cash, credit card, or check. Please be advised that payment by check binds you to a contractual agreement that holds you responsible for any and all service fees, and incidental damages allowable by law if the check is returned unpaid. Returned checks, state fees, and incidental fees may be debited from your account electronically or by paper draft. Payment by check constitutes your acceptance of these terms.

Fees: R. Brent Jackson. D.O., P.A. charges the following service fees:

- $20 extra insurance and/or disability forms
- $25 missed appointments, subject to cancellation policy of 24 hours and physician discretion
- Others based on complexity

Prescriptions: Prescription refills will be not be responded to during the weekend or after office hours under any circumstances. Please call your pharmacy and ask them to fax us a request at 210-494-9601. Allow 48 hours for all requests.

Referrals: If a referral was not obtained in advance of the appointment, and your insurance requires such referral, you will be required to make payment in full or reschedule the appointment in accordance with rescheduling guidelines.

If you are referred to Methodist Ambulatory Surgery Center North Central, we are required by law to inform you that R. Brent Jackson, D.O. has ownership interest in the facility and may receive remunerations for services rendered. Additional information is available by request to practice manager.

I have read and consent to the policies above.

_______________________________________ _______________________

Signature of Patient or Legal Representative Date

Acknowledgement Of Receipt of Notice of Privacy Practices

I acknowledge that I have been given an opportunity to review the Notice of Privacy Practices from Jackson Orthopaedics and that I may request a copy for my records if I so choose.

_______________________________________ _______________________

Signature of Patient or Legal Representative Date

Acknowledgement and Authorization to Treat

I hereby acknowledge the information given is true to the best of my knowledge and I understand the terms and agreements made with R. Brent Jackson, D.O., P.A. R. Brent Jackson, D.O., P.A. provides orthopaedic care including diagnosis and treatment of injuries or illnesses. A physician provides services at this office. I authorize and consent to diagnostic testing and treatment. I authorize employees and staff associated with R. Brent Jackson, D.O., P.A. to carry out the instructions of the physician with respect to the procedures and treatments they have ordered.

The undersigned, having read and expressed understanding of this document by the signature below, does hereby agree to be medically attended and treated by R. Brent Jackson, D.O., P.A.

____Date______/______/_____

Patient or Legal Representative Signature

Prescription History Consent

I voluntarily consent to provide R. Brent Jackson, DO PA access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that R. Brent Jackson, DO PA may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this Prescription History Consent will be valid and remain in effect as long as I attend or receive services from R. Brent Jackson, DO PA, unless revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.

I certify that I have read and understand this document.

____ ________________________
Signature of patient, parent, or legal representative Date

Insurance Fraud Acknowledgement

I understand that any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information or who conceals, for the purpose of misleading, information concerning any fact, commits a fraudulent act, which is a crime subject to criminal prosecution and civil penalties.

____ ________________________
Signature of patient, parent, or legal representative Date