Jackson Orthopaedic Clinic

Patient Information (Please Print)

Name_____ Date of Birth _____ Sex: F or M

Mailing Address_____

City_____State_____Zip_____

Home Phone _____ Cell Phone _____

E-mail Address _____ Work Phone _____

Marital Status ☐M ☐D ☐S ☐W SSN _____ Race _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐ Choose not to answer ☐ Other

Name of Employer_____

Primary Care Physician: _____

Which doctor referred you to Jackson Orthopaedic Clinic? _____

Responsible Party Information (if patient is responsible party, skip this section)

Name _____

Mailing Address _____

City_____State_____Zip_____

Date of Birth _____ SSN _____

Relationship to Patient _____

Insurance Information

Primary Insurance_____ ID # _____

Insured's Name _____Date of Birth _____

Relationship to Patient _____

Mailing Address_____

City_____State_____Zip_____

Secondary Insurance _____ ID # _____

Insured's Name _____Date of Birth _____

Relationship to Patient _____

Mailing Address_____

City_____State_____Zip_____

IS THIS RELATED TO A WORK INJURY? ◯Yes ◯ No **Date of Injury** _____

IS A THIRD PARTY INVOLVED (ex. MVA, lawsuit)? ◯Yes ◯ No

Authorized Persons
Please list any person authorized to speak with us on your behalf.

_____

Name Phone Number Relation to patient

_____

Name Phone Number Relation to patient

Preferred Pharmacy Information

Pharmacy Name _____ City _____

Name of Street _____Phone Number _____

Do you authorize Jackson Orthopaedic Clinic to receive your prescription history electronically?____Yes _____ No

University of Mississippi Medical Center Family Medicine Resident Program
JOC has residents (medical doctor in training) from the University of Mississippi Medical Center accompany our physicians on monthly rotations. This resident will observe and assist your physician at the time of your visit.

Do you agree to allow the resident in your exam room during your visit? _____ Yes _____ No

_____

Signature Date

I have read the Financial Policy of Jackson Orthopaedic Clinic and agree to the conditions in the policy.

_____ _____

Signature Date

I have read the Consent for Treatment for Jackson Orthopaedic Clinic and agree to the conditions of the consent.

_____ _____

Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

For Office Use Only
We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:
☐The patient refused to sign.
☐Due to an emergency situation, it was not possible to obtain an acknowledgement.
☐We weren't able to communicate with the patient.
☐Other (provide specific details)

_____ _____

Employee Signature Date

Jackson Orthopaedic Clinic
Medical History

MEDICATIONS □NONE

Medication	Dose	Time/Day	Medication	Dose	Time/Day

MEDICAL HISTORY (List any current medical problems.) □NONE

_____ _____
_____ _____
_____ _____

ALLERGIES □NONE

_____ _____
_____ _____

SURGICAL HISTORY (List ALL surgeries with dates if possible) □NONE

_____ _____
_____ _____
_____ _____

FAMILY HISTORY (List parents, siblings and children with medical conditions)

_____ _____
_____ _____
_____ _____

SOCIAL HISTORY

Do you smoke? □Yes □No

REVIEW OF SYSTEMS

□Weight Change
□Fatigue
□Vision Problems
□Sleep Apnea
□Wheezing
□Chest pain at rest
□Chest pain with exertion
□Difficulty breathing with exertion
□Irregular heartbeat
□Shortness of breath
□Easy bruising
□Prolonged bleeding
□Pregnant
□Cold extremities
□Decreased sensation in extremities
□Pain/cramping in legs after exertion
□Keloid formation
□Balance difficulty
□Dizziness
□Gait abnormality
□Loss of strength
□Loss of use of extremity
□Tingling/Numbness
□Substance abuse

VITALS

Height _____ Weight _____