

Patient Information – Part 1

Appointment Date _____ Doctor _____

Patient Identification

Patient Name _____ Male ___ Female ___
First Middle Initial Last

Address _____ Apt. # _____ City & State _____ Zip _____

Social Security # _____ Birth Date _____ Age _____ Height _____ Weight _____

Single ___ Married ___ Divorced ___ Widowed ___

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Are you currently working? Yes ___ No ___

Job Duties/Title _____ Email Address _____

Emergency Contact:

Name: _____ Relationship: _____

Phone Number: _____

Insurance Information:

Is this a work related problem? Yes _____ No _____ Is this due to an auto injury? Yes _____ No _____

Who is your regular Doctor? _____ When were you last in that office? _____

Primary Insurance

Secondary Insurance

Insurance Name _____

Insurance Name _____

Policy Holder Name _____

Policy Holder Name _____

Policy Holder DOB _____

Policy Holder DOB _____

Policy # _____

Policy # _____

Relation to Pt: Self ___ Spouse ___ Parent ___ Other ___

Relation to Pt: Self ___ Spouse ___ Parent ___ Other ___

Policy Holder Employer _____

Policy Holder Employer _____

PROBLEM: Is this due to an injury? Yes ___ or No ___ If Yes, give Date of Injury _____

Who referred you to Johnson County Orthopedics? _____

What problem are you being seen for today? (**Include Body part, Left or Right, and Symptoms**) Date of onset of symptom(s):

IS THIS DUE TO AN INJURY? Yes _____ No _____ Date of Injury: _____

How and where did it happen? (**what** were you doing, **where** was it, etc.) _____

Have you had any of the following for **this problem**?

X-Rays (last 6 months)? Yes ___ No ___ Taken where? _____

Other testing for this problem? Yes ___ No ___ (MRI, Cat Scan, Bone Scan), other _____

Undergone physical therapy? Yes ___ No ___

Medication for this problem? Yes ___ No ___ Please list: _____

Any other treatment? Yes ___ No ___ Please list: _____

(ice, heat, cast, etc.) _____

Do you regularly take any medication(s)? Yes ___ No ___

Please list: _____

Are you **allergic** to any medications? Yes ___ No ___

Please list **medication(s) and reaction(s)**: _____
