

New Patient Form
Dr.Huff

Date: ___ / ___ / ___
Pt # _____
D.O.B. ___ / ___ / ___

Name: _____ Age: ___ Acct# _____

Referring M.D. _____ Family M.D. _____

Height: ___ Weight: ___ Respiration: ___ Circle one: R / L Handed

Chief Complaint: _____

Injury: Y / N Date Of Injury: ___ / ___ / ___ Work Related: Y / N

How Did It Happen? _____

Please List Symptoms: _____

Have you had any X-Ray's / MRI'S / EMG'S? Please Circle: Y / N
Please list Location and Date of Each:

X-Ray- _____ Date: ___ / ___ / ___

MRI - _____ Date: ___ / ___ / ___

EMG - _____ Date: ___ / ___ / ___

Please list and explain any previous treatment:

Notes: _____

BLUEGRASS ORTHOPAEDICS & HAND CARE

DATE: _____

ACCT #: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address _____

Sex: Male Female Marital Status: Single Married Divorced Widowed

Are you employed? Yes No Employer's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact (not living with you): _____ Telephone #: _____

Address: _____ City: _____ State: _____ Zip: _____

SPOUSE/PARENT INFORMATION

Last Name: _____ First Name: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Are you employed? Yes No Employer's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

ALL PATIENTS: PLEASE FILL OUT HEALTH INSURANCE SECTION

Health Insurance Company: _____ ID#: _____

Secondary Insurance Company: _____ ID#: _____

IS THIS WORKER'S COMP? IF SO, PLEASE COMPLETE:

Employers _____ Name of W/C Carrier _____

Address: _____ Address: _____

Telephone: _____ Telephone: _____

Date of Accident: _____ Claim#: _____ Adjuster Name: _____

IS THIS AUTO? IF SO, PLEASE COMPLETE:

Name of Auto Insurance Co.: _____ Telephone: _____

Claim Office Address: _____ Claim/Policy: _____

_____ Date of Accident: _____

NOTICE

Interest may be charged on all accounts which are transferred to collections at a rate of 1 1/2% per month, annual rate of 18%. I understand that interest charges will be added to any account I have that is 90 days or more past due and hereby agree to pay such charges if levied

Signature: _____ Date: _____

BLUEGRASS ORTHOPAEDICS & HAND CARE

Name: _____ Date of Birth: _____ Today's Date: _____

Family/referring physician: _____

Attorney (if applicable): _____

1. FAMILY HISTORY RELATION

Arthritis _____
Asthma _____
Cancer _____
Chemical Dependency _____
Diabetes _____
Heart Disease _____
Stroke _____
High blood pressure _____
Kidney disease _____
Tuberculosis _____

Medical History: (check if yes)

Chicken Pox Cancer Liver disease
 Measles Poor circulation Thyroid problems
 Mumps Kidney Disease Diverticulosis
 Polio Glaucoma Rectal Bleeding
 Rheumatic Fever High Blood Pressure Kidney stones
 Diabetes Ulcers Other
 Asthma Angina
 Heart Attack Stroke

2. Patient Medication (list)

3. Allergies: (list)

4. Past Surgical History: (explain)

5. Pregnant: Yes No

6. Work History:

Currently working: Yes No

Have you been declared disabled?

Yes No

If so, by what cause: _____

8. Habits:

Tobacco: Yes No How many packs? _____

Alcohol: Yes No How many drinks? _____

Drug Use: Yes No

9. Have you had any of these symptoms within the past 4 weeks? (check if yes)

Fever Chest Pain Bleeding
 Headache Palpitations Different Urination
 Weight loss Irregular heartbeat Frequent urination
 Sweats Short of breath Easy bruising
 Vision problems Swelling legs Change in moles
 Sore throat Abdominal Pain Rashes
 Hearing loss Bowel changes Other
 Nose bleeds Constipation
 Ringing ears Diarrhea

Patient Signature

Date