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: ___________________________

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NOTICE
Interest may be charged on all accounts which are transferred to collections at a rate of 1 '/2% per month, annual rate of 18%. I understand mat 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 it levied

Signature: ____ Date: ____________________________

BLUEGRASS ORTHOPAEDICS & HAND CARE

Name: ________________________________ Date of Birth: ___________ Today's Date: ___________

Family/referring physician:____

Attorney (if applicable): ____

1. FAMILY HISTORY **RELATION**

Condition	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