



JACKSON ORTHOPAEDICS

H A N D • W R I S T • E L B O W • S H O U L D E R

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: _____

Referred by: _____

Occupation: _____ Employer: _____

Hand Dominance: Right Left Ambidextrous

Is this a work-related complaint: No Yes

Date of injury and/or when you first noticed the problem: _____

If you had an injury, how did the injury occur: _____

Description of Complaint, including location of problem/injury:

Frequency of symptoms?

Rarely Sometimes Off & On Often Constantly

What makes your symptoms worse?

Increased activity/exercise Gripping/squeezing Overhead activity _____

Treatments you have tried?

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

NSAIDs (Advil/Aleve) _____

Other medical provider _____



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Name: _____

Medications:

Medications/Dose (including OTC & Vitamins)

Medications Cont.

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

Surgery

Illness/Hospitalizations

MEDICAL history: (CHECK all that apply)

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> MRSA Infection |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> HIV | <input type="checkbox"/> Heart Failure |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Depression | <input type="checkbox"/> Tuberculosis |

Other Medical History: _____

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

- | | | | | | |
|-----------------------------------|---------------------------------------|---|--|--|--------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Eyesight | <input type="checkbox"/> Hearing | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Swallowing | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Balance | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Painful Urination | |

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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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.

Patient or Legal Representative Signature

Date ____ / ____ / ____



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