ARKANSAS BONE&JOINT

2010 ACTIVE WAY | BENTON, AR 72019 | PHONE (501) 315-0984 | FAX (501) 847-1405

PLEASE CIRCLE THE NAME OF THE PHYSICIAN YOU ARE SEEING TODAY:

Dr. Jerry Lorio **Dr. Mark Bailey**

PATIENT INFORMATION

PLEASE CIRCLE: NEW PATIENT or ESTABLISHED PATIENT

LAST NAME: _____
FIRST NAME: _____
MAILING ADDRESS: _____
CITY: _____ **STATE** _____ **ZIP** _____
PHYSICAL ADDRESS: _____
CITY: _____ **STATE:** _____
ZIP CODE: _____ **SEX:** _____
PRIMARY PHONE: _____
SECONDARY PHONE: _____

DATE OF BIRTH: _____ **AGE:** _____
SOCIAL SECURITY NUMBER: _____
RACE: _____ **LANGUAGE:** _____
MARITAL STATUS: _____
OCCUPATION: _____
EMPLOYER: _____
EMERGENCY CONTACT NAME: _____
EMERGENCY CONTACT NUMBER: _____
EMAIL ADDRESS: _____

INSURANCE INFORMATION

RESPONSIBLE PARTY: _____
PHONE: _____ **DOB:** _____
PRIMARY INSURANCE: _____
ID# _____ **GROUP #** _____
POLICY HOLDER NAME: _____
DOB: _____ **SOCIAL SECURITY#** _____
RELATIONSHIP TO PATIENT: _____
ADDRESS IF DIFFERENT FROM PATIENT: _____
_____
EMPLOYER: _____

SECONDARY INSURANCE: _____
ID# _____ **GROUP #** _____
POLICY HOLDER NAME: _____
DOB: _____ **SOCIAL SECURITY#** _____
RELATIONSHIP TO PATIENT: _____
ADDRESS IF DIFFERENT FROM PATIENT: _____
_____
EMPLOYER: _____

PRIMARY CARE PHYSICIAN: _____
REFERRING PHYSICIAN: _____

PHARMACY: _____

Consent and Authorization

I request that payment of insurance benefits be made on my behalf to Arkansas Bone and Joint for any service furnished to me by any physician in the clinic. I authorize any holder to release any personal medical information needed to determine benefits to my insurance carrier, and where applicable, I further authorize the clinic, its agents or its assignees to verify employment, wage, or other data as considered necessary. I understand that I am financially responsible to the Arkansas Bone and Joint for regular and customary charges that exceed my insurance coverage. I understand that I am responsible for any charges not covered by my insurance.

_____ _____

Signature of Patient or Legal Guardian Date

The signature below acknowledges a copy of the notice; Patient Privacy Practices was RECEIVED (not necessarily read).

_____ _____

Signature of Patient or Legal Guardian Date

Message Consent: Arkansas Bone and Joint is dedicated to providing you fast and reliable information concerning your care. In many cases, we may not be able to talk to you directly because you may be away from your telephone. A convenient alternative is to leave a message for you to check later. However, voice messages may contain confidential issues. If you do not have any of the devices below, simply leave them blank.

I authorize the staff of Arkansas Bone and Joint to leave or transmit important and potentially confidential information to one or more of the following:

☐ Answering machine at your home telephone number (please list no. if different from front page)
_____

☐ Voice mail at your work but only if the voice mail message has your name (please list no. if different from front page) _____

☐ Voice mail to your Cell Phone (please list no. if different from front page) _____

NO ONE WILL BE ABLE TO ACCESS INFORMATION ABOUT YOU EXCEPT YOU, UNLESS YOU FILL OUT THE BELOW ADDENDUM.

ADDENDUM: PATIENT PRIVACY

I _____authorize Arkansas Bone and Joint to share pertinent "Protected Health Information" with my immediate family members or significant others, as noted below:

Name	Relationship	Telephone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that I may withdraw the above authorization at any time, with a written request. I also understand that it is my responsibility to inform all family members or significant others not to disclose or use this information at any time or in any way without my permission.

Signature of Patient or Legal Guardian

Date

ARKANSAS BONE&JOINT

Patient Name: _____ **Date of Birth:** _____ **Todays Date:** _____

Height: _____ **Weight:** _____

What is the nature of your problem: _____

Date of injury or when did it start : _____ **How injury occurred** _____

Occupation: _____ **When did you last work:** _____

Are there any activities that increase your pain or that you cannot do because of this problem?

_____

_____

Have you been hospitalized for this problem: YES NO if yes, when and where: _____

Have you had therapy for this problem: YES NO if yes, when and where: _____

Have you seen other physician for this problem: YES NO if yes, when and where: _____

Please circle any of the following test done for this problem in the past year:

X-RAYS MRI CT SCAN BONE SCAN EMG MYELOGRAM

Date and location of test: _____

Preferred pharmacy name: _____ Preferred pharmacy phone number : _____

Medications (please list all current medications or check option which applies):

- ☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)
- ☐ Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

Allergies **Have you ever been told you have an allergy to metal? Yes No**

_____

_____

_____

- ☐ no known allergies

Past Medical History (please check all that apply):

- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Cancer _____
- ☐ Chronic Pain
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non Insulin Dependent
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Thyroid Disease
- ☐ Hypertension
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity
- ☐ PBPH
- ☐ Radiation Therapy
- ☐ Seizures
- ☐ Stroke
- ☐ **None**
- ☐ Other_____

Past Surgical History (please check all that apply):

- ☐ Appendix (Appendectomy)
- ☐ Bladder Removed
- ☐ Breast: Mastectomy ORight OLeft OBoth
- ☐ Breast: Lumpectomy ORight OLeft OBoth
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Gallbladder Removal
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Removed: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Hysterectomy
- ☐ **None**
- ☐ Other_____

Past Orthopedic History (please check all that apply):

- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Bursitis
- ☐ DISH
- ☐ Epidural Injections, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ **None**
- ☐ Other_____

Past Orthopedic Surgery (please check all that apply):

- ☐ Ankle Fracture ORIF
  ORight OLeft OBoth
- ☐ Carpal Tunnel Decompression
  ORight OLeft OBoth
- ☐ Distal Radius ORIF
  ORight OLeft OBoth
- ☐ Intermedullary Nailing Femur
  ORight OLeft OBoth
- ☐ Intermedullary Nailing Tibia
  ORight OLeft OBoth
- ☐ Joint Replacement: Hip
  ORight OLeft OBoth
- ☐ Joint Replacement: Knee
  ORight OLeft OBoth
- ☐ Joint Replacement: Shoulder
  ORight OLeft OBoth
- ☐ Knee Arthroscopy
  ORight OLeft OBoth
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Lumbar Spine Surgery:_____
- ☐ Cervical Spine Surgery:_____
- ☐ Thoracic Spine Surgery:_____
- ☐ Rotator Cuff Repair
  ORight OLeft OBoth
- ☐ Other_____

Family History (please inform us of your family members' medical history by marking the appropriate box):

	Mother	Father	Sister	Brother	Daughter	Son	Other:
Hypertension							
Osteoarthritis							
Osteoporosis							
Scoliosis							
Diabetes							
Other							

☐ **No Family History** (checking this box indicates no past family medical history)

Social History (please check all that apply): Have you had a flu shot? _____ Have you had a pneumonia shot? _____

Have you had your Covid 19 Vaccination? _____ Have you ever or are you currently using drugs? YES NO

Cigarette Smoking
- ☐ Never Smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily
  - o # packs per day_____

Alcohol Use
- ☐ Do not drink alcohol
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Exercise Frequency
- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never
- ☐ Other_____

Review of Systems* (circle if you are currently experiencing any of the following):

joint pains	tingling	unexpected weight loss/gain	fainting	ringing in ears
joint swelling	dizziness	easy bleeding	hoarseness	blurred vision
joint stiffness	headaches	easy bruising	heart murmur	heartburn
unsteady gait	tremors	chest pain	leg cramps	nausea
numbness	fatigue	palpitations	nose bleeds	difficult/painful urination
constipation	diarrhea	bloody/tarry stools	frequent urination	cough
incontinence	blood in urine	shortness of breath	wheezing	
hurts to breath	nervousness	anxiety	depression	

Alerts* (circle all that apply):

blood thinners	pacemaker	defibrillator	premedication	rheumatoid arthritis
RSD	allergy to shellfish/iodine	allergy to latex	allergy to adhesive	under pain management

ARKANSAS BONE&JOINT

Financial Agreement

2010 ACTIVE WAY BENTON, ARKANSAS 72019 Phone: (501) 315-0984 Fax: (501) 847-1405

We will gladly file your insurance for all claims, taking into consideration that your insurance may not cover certain items such as soft goods (DME), injections, or any other miscellaneous items, in accordance with the terms of your insurance contract. We will gladly contact your insurance to pre-certify any outpatient testing and surgery. For those with Arkansas Medicaid, at times a beneficiary is responsible for non-covered charges, including services received in excess of Medicaid benefit limitations.

I hereby agree by signing that I will be responsible for those items that are not covered by insurance.
Your signature agreement will be effective for one year.

Patient Signature: _____
Guardian signature: _____
(If patient is a minor)

Date: _____

Medicaid/AR Kids A& B: Casting materials and steroids are not covered under this policy.
AR Kids: Durable Medical Equipment is not covered under this policy