Physician Name: Kyle F. Dickson, M.D.

PATIENT DEMOGRAPHIC INFORMATION SHEET

Last Name ______ First Name ______ Middle ______ Social Security No. ______

Date of Birth ______ Age ______ Male or Female *(Please circle one)* Marital Status: M S W D *(Please circle one)*

Home Address ______ City ______ State ______ Zip ______

Home Phone ______ Work Phone ______ Cell Phone ______

Contact Preference: *(Please Check One)* ___ Home ___ Work ___ Cell ___ Mail ______ Email Address

Referred By: ______ Phone #: ______

EMERGENCY CONTACT INFORMATION

Name ______ Phone No. ______ Alt. Phone ______ Relationship ______

PATIENT EMPLOYER INFORMATION

Employer Name ______ Phone ______ Fax ______

Address ______ City ______ State ______ Zip ______

GUARANTOR / POLICY HOLDER INFORMATION

Last Name ______ First Name ______ Middle ______ Social Security No. ______

Date of Birth ______ Patient's Relationship to Policy Holder ______ Home Phone ______ Cell Phone ______

Employer Name ______ Phone ______ Fax ______

Employer Address ______ City ______ State ______ Zip ______

INSURANCE INFORMATION

Primary Insurance	Name of Primary Insurance	ID/Policy Number	Group Number	Customer Service No.
Secondary Insurance	Name of Secondary Insurance	ID/Policy Number	Group Number	Customer Service No.
Work Comp Insurance	Name of WC Insurance	Claim #	Adjuster Name	Adjuster Phone No.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT RELEASE ME FROM MY PERSONAL RESPONSIBILITY FOR PAYMENT OF ALL CHARGES WITHIN 50 DAYS. **AUTHORIZATION TO RELEASE INFORMATION:** I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OF TREATMENT.

Signature: ______ Date: ______

SOUTHWEST
Orthopedic Group, L.L.P.

KYLE F. DICKSON, M.D.

NEW PATIENT HISTORY FORM

Patient Name ______________________ Age ________ Date ____________

Occupation ______________________ Gender ____________ Circle: Left or Right handed

Who may we thank for your referral: ______________________

Current Problem: ______________________ Date problem began ____________

Are you experiencing any of the following: (circle)
Pain Swelling Redness Limited Motion Weakness Atrophy Cramps
Popping Locking/Catch Stiffness Numbness Tingling Mass Deformity

Have you been treated for this problem before? ______ What kind of treatment: Medication Injection
Splint/Brace Therapy Surgery X-rays MRI Nerve Test Other: ____________

Are you allergic to any medications? ______________________

Have you ever had an adverse reaction to a blood transfusion? ______________________
Do you have an allergy to tape or adhesives? ______ Have you ever had problems with anesthesia? ____________
Have you ever been hospitalized or had surgery? ________ Surgeries: ______________________

CURRENT MEDICATIONS

Please list all medications you are currently taking, including aspirin, herbal remedies, and any over-the-counter medications. (If you are taking more than 6 medications, continue on reverse side).

Medication	Strength	How Often Taken

Have you ever used steroid medications (cortisone, prednisone, etc.)? No [ ] Yes [ ]

HABITS

Tobacco Use	No	Yes	Type and Amount per Day	____________
Alcohol Use	No	Yes	Type and Frequency	____________
Drug use	No	Yes	Type and Frequency	____________
Caffeine Use	No	Yes	Type and Frequency	____________
Exercise	No	Yes	Type and Frequency	____________

HEALTH

Do you have, or have you ever had, any of the following? ***Check all that apply.***

- ☐ AIDS/HIV+
- ☐ Arthritis, bursitis
- ☐ Asthma
- ☐ Back Pain
- ☐ Blood clots
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes (Sugar)
- ☐ Epilepsy or seizures
- ☐ Excessive bleeding
- ☐ Gallbladder trouble
- ☐ Glaucoma
- ☐ Gout
- ☐ Hay fever
- ☐ Heart attack
- ☐ Heart disease
- ☐ Hemorrhoids
- ☐ Hepatitis or jaundice
- ☐ Hernia
- ☐ Hypertension/High blood pressure
- ☐ Kidney disease
- ☐ Kidney stone
- ☐ Leukemia
- ☐ Loss of any part of arm/leg
- ☐ Lung disease
- ☐ Osteoporosis
- ☐ Palsy
- ☐ Pancreatitis
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Psychiatric treatment
- ☐ Pulmonary Embolism
- ☐ Rheumatic Fever
- ☐ Rheumatoid arthritis
- ☐ Scarlet Fever
- ☐ Strokes
- ☐ TB
- ☐ Thyroid disease
- ☐ T.I.A.
- ☐ Tumor/growth/cyst
- ☐ Ulcer-gastric
- ☐ Ulcer-peptic
- ☐ Venereal disease
- ☐
- ☐ Other ____________
- ☐ ____________
- ☐ ____________
- ☐ ____________

Who is your primary care physician: ______________________________ Phone: ____________________

REVIEW OF SYSTEMS: (Check all that you have experienced recently)

General

- ☐ Weight loss
- ☐ Weight gain
- ☐ Poor appetite
- ☐ Chills
- ☐ Fever
- ☐ Night sweats

Skin

- ☐ Rash
- ☐ Hives
- ☐ Lesions

Head/Eyes/Ears/Nose/Throat

- ☐ Postnasal drip
- ☐ Hoarseness
- ☐ Visual problems
- ☐ Nose bleeds
- ☐ Neck stiffness/pain

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Other ____________

Pulmonary

- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Coughing
- ☐ Coughing up blood

Genitourinary

- ☐ Frequent urination (frequency)
- ☐ Urgent urination (urgency)
- ☐ Painful urination (dysuria)
- ☐ Need to awaken to urinate
- Blood in urine
- ☐ Kidney stone pain

Gastrointestinal

- ☐ Indigestion
- ☐ Gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Yellow skin
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black stools
- ☐ Rectal bleeding

Musculoskeletal

- ☐ Pain
- ☐ Swelling
- ☐ Redness
- ☐ Limited motion
- ☐ Weakness
- ☐ Atrophy
- ☐ Cramps
- ☐ Popping
- ☐ Locking/catching
- ☐ Stiffness
- ☐ Numbness
- ☐ Mass

Lymphatics

- ☐ Lymph node swelling
- ☐ Node tenderness

Endocrine

- ☐ Excessive urination
- ☐ Excessive thirst
- ☐ Excessive appetite
- ☐ Hot intolerance
- ☐ Cold intolerance
- ☐ Easy bleeding

Cardiovascular

- ☐ Chest pain (angina)
- ☐ Palpitations (rapid heartbeat)
- ☐ Irregular heartbeat (arrhythmia)
- ☐ Rheumatic fever
- ☐ Swollen ankles (pedal edema)
- ☐ Shortness of breath on exertion
- ☐ Shortness of breath at night

Neurological

- ☐ Loss of consciousness
- ☐ Headaches
- ☐ Seizures (fits)

Height ____________

Weight ____________

Dominance

- ☐ Right handed
- ☐ Left handed

FAMILY HEALTH Have blood relatives ever had any of the following? If so, indicate their relationship to you (e.g. Diabetes-maternal grandmother)

- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Heart Trouble
- ☐ Liver Trouble
- ☐ High Blood Pressure
- ☐ Any Unusual Disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Blood Disease
- ☐ Psychiatric Disease
- ☐ Unusual Reaction to Anesthesia
- ☐ Stroke

If your mother, father, or any of your brothers and/or sisters have died, what was the cause of their death and what was the age at the time of death? ______________________________

I certify that the information provided above is true.

Patient Signature ______________________________ Date ____________

Relationship: __ Self
__ Parent or Legal Guardian
__ Other: ______________________________
(Please Specify)

Pharmacy Name: ____________

Pharmacy Phone #: ____________

Physician Notes: ______________________________

Physician Signature ______________________________ Date ____________

SOUTHWEST ORTHOPEDIC GROUP, LLP

Review of Notice of Privacy Practices

Acknowledgement:

I acknowledge that I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_______________________________________ ____________________
Patient or Personal Representative **Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____________________________.

Financial Policy Statement

It is the policy of Southwest Orthopedic Group, LLP, to bill your insurance carrier as a courtesy to you; however, you are responsible for the entire bill. We require that arrangements for payment of your estimated share be made today. The insured/patient is responsible for any co-payments at the time service is rendered. If your insurance carrier does not remit payment within sixty (60) days, the balance will be due in full from you. If your insurance pays in excess of the balance of your account, we will refund the credit.

If any payment is made directly to you for services billed by Southwest Orthopedic Group, LLP, you recognize an obligation to promptly remit payment to Southwest Orthopedic Group, L.L.P.

The above does not apply to those patients that are considered Workers' Compensation. However, be advised as a Workers' Compensation patient that you may be held responsible for your charges in the event that your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Southwest Orthopedic Group, LLP, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

_______________________________________ __________________________
Responsible Party Print Name **Date**

____
Responsible Party Signature

SOUTHWEST ORTHOPEDIC GROUP, L.L.P.

AUTHORIZATION FOR COMMUNICATION OF MEDICAL INFORMATION

Patient Name: ____ *DOB:* _______________

Address: ____ *Telephone#*___________

In order for our practice to respond promptly and accurately to your needs, Please list any person(s) whom you would like to have access to your medical information:

Name: ______________________________________ Relationship: ________________

Name: ______________________________________ Relationship: ________________

Name: ______________________________________ Relationship: ________________

Name: ______________________________________ Relationship: ________________

Name: ______________________________________ Relationship: ________________

I understand that this authorization is valid for 90 days from the date of my signature. I understand that this authorization authorizes the release of all my medical records. I further understand that I can revoke this authorization in writing at any time prior to the expiration date. In addition, I understand that any release of this information by the recipient without my further consent is prohibited. Finally, I understand that a photocopy of this authorization may be considered valid.

PRINT NAME: ____

SIGNATURE: ______________________________________ DATE: _________________