PowellOrthopedics
Knee & Shoulder / Sports Medicine

Patient Information Form

Chart# _____

Patient Name _____ _____ _____
LAST FIRST MIDDLE

Address _____
STREET, P.O. BOX AND OR SUITE #

_____ _____ _____
CITY STATE ZIP

Home Phone # _____ Cell # _____ Work # _____

DOB _____ SSN # _____ Male _____ Female _____

Employer _____ Primary Ins. Carrier _____

Patient ID # _____ Policy # _____

Secondary Ins. Carrier _____

Patient ID # _____ Policy # _____

Please fill out the name of the primary cardholder of your insurance if it is different from the patient above.

Name _____ _____ _____
LAST FIRST MIDDLE

DOB _____ SSN # _____ Male _____ Female _____

Employer _____ Work # _____

PERMISSION TO GIVE MEDICAL INFORMATION

I, _____ hereby authorize the physician and staff of Powell Orthopedics, P.A. to contact in case of emergency, or to discuss any information about health, well being, or appointments concerning the patient, with myself or spouse or with the following person or people.

1. Name _____ Phone # _____

2. Name _____ Phone # _____

This is also an agreement to obtain medical services, assignment of benefits and authorization to release medical information. I authorize any holder of medical information about me to release it to Powell Orthopedics P.A. and or staff, any information needed. I also agree to an automated telephone system to call and remind me of a scheduled appointment and I acknowledge receiving a copy of the HIPAA notice of privacy practice today. Powell Orthopedics P.A. is also authorized to furnish to any insurance company, 3rd party payer, hospital or physician any and all information it may have concerning the patient, including, but not limited to, medical history, reports, consultations, prescriptions, treatment, x-rays, and all other requested information or documentation pertaining shall be considered as a valid and effective as the original.

_____ Date _____
SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN

Mark W. Powell, M.D. Orthopedic Surgery / 3714 N. Business Drive, Suite 101 / Fayetteville, Arkansas 72703
Phone: 479-582-4647 (HOGS) / Fax: 479-582-4660
Mailing Address: P.O. Box 9688, Fayetteville, AR 72703

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New Patient Information

Date _____

Patient Name _____ DOB _____ Age _____

Referring Physician _____ M___ F___ Dominant Hand: R L Both

PLEASE TELL US ABOUT YOUR ORTHOPEDIC PROBLEM:

When did it begin? _____ What caused it? _____

Previous Treatment? Yes No By whom? _____ When? _____

PAST SURGICAL HISTORY (please list)

1. _____ Dr. _____ Date _____
2. _____ Dr. _____ Date _____
3. _____ Dr. _____ Date _____
4. _____ Dr. _____ Date _____
5. _____ Dr. _____ Date _____
6. _____ Dr. _____ Date _____

MEDICINES (prescription and non-)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

ALLERGIES (medicine or other)

_____

_____

PAST MEDICAL HISTORY: (circle all that apply)

Heart Disease	High Blood Pressure		Heart Attack
Stroke	Congestive Heart Failure		Bleeding Disorder
Blood Clots	Pulmonary Embolis		Lung Disease
Emphysema	Asthma	COPD	Cancer
Kidney Disease	Liver Disease	Diabetes	Seizure Disorder

Other Health Problems: _____

Hospitalizations (for what and when?): _____

LEGAL

Problem due to an accident? Yes No

Auto accident? Yes No

Do you have an attorney? Yes No

Is litigation planned? Yes No

Attorney's name: _____

Address/Phone: _____

PERSONAL AND FAMILY

Do you use tobacco? Yes No Amt. per day? _____ Since? _____

Do you use alcohol? Yes No Amt. per day? _____ Since? _____

Most physically demanding regular activity? _____ How often? _____

Occupation _____ Time at present employer? _____ Previous? _____

Marital Status: (circle) Single Married Divorced Widowed

Living Status: (circle) Alone Spouse Children Parents Friend(s)

Family Health: (List health problems. If deceased, please note age of death.)

Father _____ Mother _____

Siblings _____ Children _____

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powellorthopedics.com

Have you recently experienced any of the following – check if "yes".

HEENT
______Eye pain or glaucoma
______Require glasses
______Visual impairment not corrected by glasses
______Cataracts
______Trouble hearing
______Ringing of ears
______Repeated nose bleeds
______Trouble breathing through nose
______Difficulty swallowing
______Hoarseness
______Other difficulty speaking
______Lump in your neck
______Salivary gland problem

Cardiopulmonary
______Cough
______Coughing up phlegm
______Coughing up blood
______Pneumonia
______Collapsed lung
______Tuberculosis
______Asthma
______Hay fever
______Shortness of breath
______Shortness of breath walking
______Shortness of breath lying down
______Chest pain
______Heart attack
______Dizziness
______Loss of consciousness
______Rapid heart beat
______Irregular heart beat
______Rheumatic fever
______Blood clot in legs
______Phlebitis
______Pain in legs with walking
Painful whitening of fingers

GI
______Abdominal pain
______Indigestion, heartburn
______Nausea
______Vomiting
______Diarrhea
______Constipation
______Black stools
______Blood in stools
______Loss of appetite
______Ulcers
______Hiatal hernia
______Other hernia
______Jaundice
______Hepatitis
______Gallstones
______Colitis or enteritis
______Cirrhosis
______Pancreatitits
______Hemorrhoids

GU
______Urinary tract infection
______Burning with urination
______Dark or bloody urine
______Kidney stones
______Syphillis
______Gonorrhea
______Other venereal disease
______Trouble starting urination
______Bladder not emptying
______Decreased urinary stream

For Women
______Date of last menstrual period
______Are you pregnant
______Pain or other problems with intercourse
______Decreased sex drive
______Birth control pills/shots/implants

For Men
______Difficulty with erection
______Prostatitis
______Enlarged prostate
______Decreased sex drive
______Discharge from penis

Neuro
______Headaches
______Neck pain
______Back pain
______Weakness
______Numbness
______Unsteadiness
______Loss of coordination
______Tremor, shaking
______Confusion
______Memory loss
______Spells
______Seizures
______Stroke
______Traumatic brain injury

Other
______Weight loss/gain
______Joint stiffness
______Joint pain
______Joint swelling
______Poor sleeping
______Depression
______Anxiety
______Crying spells

Patient Initials	Date

PLEASE READ: The patient is responsible for all fees, regardless of insurance coverage. PAYMENT IS REQUESTED AT THE TIME OF SERVICE.

A photocopy of this authorization shall have the same effect as the original.

______________________________ PATIENT/GUARDIAN SIGNATURE

______________ DATE