Patient Registration Information

Please PRINT AND complete ALL sections below!

PATIENT'S PERSONAL INFORMATION **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Name: ______________________ ______________________ ______________________
last name first name initial

Date of Birth: Social Security #:

Home Phone: Cell Phone: Work Phone:

Address: Apt. #: City: State: Zip:

Race: ☐ Declined Ethnic Group: ☐ Declined Preferred Contact Method:

RESPONSIBLE PARTY INFORMATION **Relationship to Patient:** ☐ Self ☐ Spouse ☐ Child ☐ Other

Name:

Date of Birth: Social Security #:

Home Phone: Work Phone: Cell Phone:

Address: City: State: Zip:

PATIENT'S INSURANCE INFORMATION Please present insurance cards to receptionist.

PRIMARY Insurance Name:

Address: City: State: Zip:

Name of Policy Holder: Date of Birth: Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: Group #: Copay: $

SECONDARY Insurance Name:

Address: City: State: Zip:

Name of Policy Holder: Date of Birth: Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: Group #: Copay: $

EMERGENCY CONTACT

Name: Relationship:

Address: City: State: Zip:

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( )

Assignment of Benefits • Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to Dr. Jack L. Deetjen, M.D., and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.
I further agree that a photocopy of this agreement shall be as valid as the original.

Date: ________________ Signature: ____

JACK L. DEETJEN, M.D.
515 N. KING, SUITE 106
SEGUIN, TX 78155
830-379-8371

Acknowledgement of review of
Notice of Privacy Practices

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 upon request.

Patient Name:
Date of Birth:
Social Security Number:

____
Signature of Patient

Date:

____
Name of Personal Representative

____
Signature of Personal Representative

____
Relationship to Patient

Date

Date: ___________________

Patient Name: ______________________________________

Primary Doctor: ______________________________

Family/Primary Doctor Address: ______________________

INSTRUCTIONS: Please complete the questionnaire and answer the questions in as much detail as possible.

What are you seeing the doctor for? ____

History of problem/injury

When did the problem first start? ______________________

Duration of symptoms: ____________________

Is this an injury? ____________ Motor Vehicle accident? ____________Work related? _______________

Have you seen a doctor in the past for this problem or injury? If yes, when and who?____
____
____________.

How did this injury occur or when did the problem start?
____
____
___________.

What treatment have you had? Please list and circle below:

- o Injection
- o Aspiration
- o Physical Therapy
- o Exercise
- o Anti-inflammatory medication
- o Pain medication
- o Bracing
- o Heat/ice

- Rest
- Other: ____

<u>Please circle any Anti-Inflammatory medications that you have taken in the past</u>.

Advil   Ibuprofen   Naproxen   Diclofenac   Voltaren Gel   Mobic/ Meloxicam   Celebrex

MEDICAL HISTORY

Please circle any of the following medical problems listed below that you are currently being treated for:

- I have no known medical problems
- High Blood pressure
- Low blood pressure
- Coronary artery disease/Heart disease
- Peripheral Vascular disease
- Diabetes
- Previous Heart attack
- Asthma
- Stomach bleeding(ulcers)
- Cancer
- Osteoporosis
- Liver disease
- Seizure disorder
- Thyroid disorder
- COPD/Lung problems
- Immune disorder

Surgical History

Please indicate the year of surgery if possible.

- No previous Surgeries
- Arthroscopy_________________________
  Knee R/L   Shoulder R/L   Hip R/L
- Appendectomy
- Cataracts ____________________
- Heart surgery: procedure done? :_________________________________
- Fracture repair
- Gallbladder removal
- Hernia repair
- Tonsillectomy
- Cancer
- Hysterectomy

- Join Replacement: KNEE R/L   Shoulder R/L   Hip R/L

Other____

MEDICATIONS

List ALL medications you are currently taking.

____
____
____
____
____
____

Please provide pharmacy name:

____

Location: ____

Please list any allergies below

____

Height: _________ Weight: _________

SOCIAL HISTORY

Do you consume alcohol? Yes   no

Do you smoke or have ever smoked? Yes   no

- Currently a smoker: _____ packs a day _____ years
- Former smoker: _____packs a day ______ years   Quit:__________

EVERYTHING I HAVE ANSWERED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

Patient signature

____