



ARKANSAS BONE & JOINT

2010 ACTIVE WAY
BENTON, AR 72019
PH: 501-315-0984 FAX: 501-847-1405

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

DR. JERRY LORIO

DR. SCOTT WALSH

DR. MARK (BJ) BAILEY

DR. JEFFREY JOHNSON

PATIENT INFORMATION

LAST NAME: _____
FIRST NAME: _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHYSICAL ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PRIMARY PHONE NUMBER: _____
SECONDARY PHONE NUMBER: _____

DATE OF BIRTH: _____ AGE: _____
SS#: _____
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: _____ SS#: _____
RELATIONSHIP TO PATIENT: _____
ADDRESS IF DIFFERENT FROM PATIENT: _____
EMPLOYER: _____

SECONDARY INSURANCE: _____
ID#: _____ GROUP#: _____
POLICY HOLDER: _____
DOB: _____ SS#: _____
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

Name

Relationship

Telephone Number

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):

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia, Chronic | <input type="checkbox"/> Diabetes, Non Insulin Dependent | <input type="checkbox"/> Multiple Myeloma |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD | <input type="checkbox"/> PBPH |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> None |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hypertension | <input type="checkbox"/> <u>Other</u> |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lcukemia | |
| <input type="checkbox"/> Diabetes, Insulin Dependent | <input type="checkbox"/> Lymphoma | |

Past Surgical History (please check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Appendix (Appendectomy) | <input type="checkbox"/> Heart: Coronary Artery Bypass Surgery | <input type="checkbox"/> Prostate Removed: Prostate Cancer |
| <input type="checkbox"/> Bladder Removed | <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Prostate Removed: TURP |
| <input type="checkbox"/> Breast: Mastectomy
○Right ○Left ○Both | <input type="checkbox"/> Heart: Mechanical Valve Replacement | <input type="checkbox"/> Rectum: APR |
| <input type="checkbox"/> Breast: Lumpectomy
○Right ○Left ○Both | <input type="checkbox"/> Heart: PTCA | <input type="checkbox"/> Rectum: Low Anterior Resection |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection | <input type="checkbox"/> Kidney Stone Removal | <input type="checkbox"/> Skin: Basal Cell Carcinoma |
| <input type="checkbox"/> Colectomy: Diverticulitis | <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> Skin: Melanoma |
| <input type="checkbox"/> Colectomy: IBD | <input type="checkbox"/> Liver: Liver Transplant | <input type="checkbox"/> Skin: Skin Biopsy |
| <input type="checkbox"/> Colon: Colostomy | <input type="checkbox"/> Liver: Shunt | <input type="checkbox"/> Skin: Squamous Cell Carcinoma |
| <input type="checkbox"/> Gallbladder Removal | <input type="checkbox"/> Ovaries Removed: Ovarian Cancer | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Heart: Biological Valve Replacement | <input type="checkbox"/> Ovaries: Tubal Ligation | <input type="checkbox"/> None |
| | <input type="checkbox"/> Pancreas: Pancreatectomy | <input type="checkbox"/> <u>Other</u> |

Past Orthopedic History (please check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Ankle Fracture | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Soft Tissue Sarcoma |
| <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Spinal Stenosis, Cervical |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Spinal Stenosis, Lumbar |
| <input type="checkbox"/> DISH | <input type="checkbox"/> Primary Bone Sarcoma | <input type="checkbox"/> Vertebral Body Compression Fracture |
| <input type="checkbox"/> Epidural Injections, Spine | <input type="checkbox"/> Psoriatic Arthritis | <input type="checkbox"/> Vitamin D Deficiency |
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Wrist Fracture |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Ricketts | <input type="checkbox"/> None |
| <input type="checkbox"/> Hip Fracture | <input type="checkbox"/> RSD | <input type="checkbox"/> <u>Other</u> |
| <input type="checkbox"/> HNP, Cervical | <input type="checkbox"/> Sciatica | |
| <input type="checkbox"/> HNP, Lumbar | <input type="checkbox"/> Scoliosis | |
| <input type="checkbox"/> Metastatic Bone Disease | <input type="checkbox"/> Spine Fracture | |

Past Orthopedic Surgery (please check all that apply):

- Ankle Fracture ORIF
 Right Left Both
- Carpal Tunnel Decompression
 Right Left Both
- Distal Radius ORIF
 Right Left Both
- Intermedullary Nailing Femur
 Right Left Both
- Intermedullary Nailing Tibia
 Right Left Both
- Joint Replacement: Hip
 Right Left Both
- Joint Replacement: Knee
 Right Left Both
- Joint Replacement: Shoulder
 Right Left Both
- Knee Arthroscopy
 Right Left Both
- Kyphoplasty/Vertebroplasty
- Lumbar Spine Surgery: _____
- Cervical Spine Surgery: _____
- Thoracic Spine Surgery: _____
- Rotator Cuff Repair
 Right Left Both
- 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 |



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 authorization. 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 below that I will be responsible for those items that are not covered by insurance or fall as patient responsibility.

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