



Dr. Joseph Kendra

Date: _____

Social Security Number: _____ - _____ - _____

Patient Name: _____
Last First Middle Initial Date of Birth Age

Mailing Address: _____ City: _____ Zip: _____

Street Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient Employer: _____ Employer's Phone Number: _____

Male Female Race: _____ Non Hispanic Hispanic Language: _____

Pharmacy: _____ City: _____

Email Address: _____

➤ SPOUSE'S INFORMATION:

Name: _____ Social Security Number: _____ - _____ - _____

Mailing Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ - _____ - _____ Employer: _____

➤ RESPONSIBLE PARTY (IF SOMEONE OTHER THAN PATIENT) Relation to Patient: _____

Name: _____ Social Security Number: _____ - _____ - _____

Mailing Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ - _____ - _____ Employer: _____

➤ EMERGENCY CONTACT PERSON: (*Must have phone number different than patient*)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Date of Birth: _____

➤ METHOD OF PAYMENT: Cash Insurance Worker's Comp

Is your visit related to employment / work-related injury? _____

PATIENT NAME: _____

➤ PROBLEM YOU ARE HAVING TODAY / COMPLAINT: _____

Date of Injury: _____

Referred by: _____

Family Physician: _____

➤ MEDICAL HISTORY

Please check the appropriate box.

Heart Disease: Yes No Diabetes: Yes No Height: ____ ft ____ inches

Stroke: Yes No Thyroid: Yes No Weight: _____

Ulcers: Yes No High Blood Pressure: Yes No

Blood Clots: Yes No

Cancer: Yes No If yes, what type? _____

Do you have a history of COVID? Yes No Have you completed the COVID vaccine series? Yes No

Do you have a pacemaker? Yes No

Are you taking ANY blood thinners? Yes No If yes, what type? _____

Please list any other medical problems not listed above: _____

Tobacco Use: Present User Former User Never Used

Do You Drink Alcoholic Beverages: Yes No If yes, Occasional Moderate Heavy

Have you ever had a fracture (broken bone?) Yes No

If yes, please list: _____

Have you ever had surgery? Yes No If yes, please list all surgeries: _____

Are you allergic to any medications? Yes No If yes, please list _____

PATIENT NAME: _____

➤ **CURRENT MEDICATIONS:** Please list ALL medications you are currently taking and the dosage. Please include all prescription and over the counter medications.

CHECK HERE IF YOU TAKE NO PRESCRIPTION OR OVER THE COUNTER MEDICATIONS.

<u>MEDICATION</u>	DOSAGE (mg, etc.)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
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_____	_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Orthopaedic Associates' Notice of Privacy Practices. By signing below I am only giving acknowledgement that I have received or have had the opportunity to receive the Notice of Privacy Practices.

Patient Name (Printed)

Date

Signature: _____

RELEASE OF INFORMATION AUTHORIZATION:

Due to federal privacy guidelines (HIPPA), Orthopaedic Associates is not allowed to divulge information to anyone other than the patient (or guardian of the patient) unless explicit written authorization is given to discuss personal medical information with someone other than you.

I, _____, give Orthopaedic Associates permission to release / discuss personal medical information to include the pickup of prescriptions and / or financial information to:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Signature of Patient: _____

Date: _____

GUARANTEE OF ACCOUNT: MUST BE 19 YEARS OF AGE TO SIGN

I, the undersigned, directly assign to Orthopaedic Associates all surgical and / or medical benefits, if any, otherwise payable to me for services rendered.

In consideration of services rendered or to be rendered, the undersigned agrees to pay all costs of collection and / or reasonable attorney fees, should the account be turned over to enforce collections of said charges. The undersigned hereby waives all claims or rights of exemption allowed by the constitution of the state of Alabama or any other state of the United States.

I hereby authorize Orthopaedic Associates to release any information necessary to secure payment of benefits to my account.

Signature: _____

Date: _____

May we leave voicemails on the numbers you've provided? Yes No

Comments: _____