ARKANSAS ORTHOPEDICS & SPORTS MEDICINE
Demographics Page

**PATIENT INFORMATION: TODAY'S DATE_____

FIRST NAME_____MIDDLE_____LAST NAME_____

GENDER (circle one) MALE - FEMALE.....MARITAL STATUS (circle one) SINGLE - MARRIED - DIVORCED - WIDOWED

DATE OF BIRTH_____ SOCIAL SECURITY NUMBER_____

MAILING ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

EMPLOYER_____ADDRESS_____

IF PATIENT IS A MINOR:
*MOTHER'S NAME_____DATE OF BIRTH_____

SS#_____EMPLOYER & ADDRESS_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

*FATHER'S NAME_____DATE OF BIRTH_____

SS#_____EMPLOYER & ADDRESS_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

IF PATIENT IS MARRIED:
SPOUSE'S NAME_____DATE OF BIRTH_____

SS#_____EMPLOYER & ADDRESS_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

INSURANCE INFORMATION:
*PRIMARY INSURANCE_____ MEMBER/SUBSCRIBER ID_____

NAME OF INSURED_____DATE OF BIRTH_____SS#_____

*SECONDARY INSURANCE_____ MEMBER/SUBSCRIBER ID_____

NAME OF INSURED_____DATE OF BIRTH_____SS#_____

PRIMARY CARE DR_____ADDRESS_____PHONE_____

REFERRING DR_____ADDRESS_____PHONE_____

EMERGENCY CONTACTS:

1)_____PHONE_____

2)_____PHONE_____

******* HOW DID YOU HEAR ABOUT US? (circle one) PCP - HOSPITAL - RADIO - NEWSPAPER - ONLINE - FRIEND/FAMILY

ARKANSAS ORTHOPEDICS and SPORTS MEDICINE

Patient's Name: _____ Patient age _____ Date: _____

CURRENT INJURY OR PROBLEM

Please describe the reason for your visit today [What is injured, hurts or is bothering you]: _____

_____

_____

Onset Date [when did the injury or condition start?]: _____

How did it happen? _____

_____

Where did it happen? ☐Home ☐Public ☐School ☐Work ☐Auto ☐Other: _____

Was this a result of an injury? ☐Yes ☐No Are you claiming this as work related? ☐Yes ☐No

Have you been seen by any other doctor for this injury/condition? ☐Yes ☐No

If yes, who? _____ When did you see the other doctor? _____

Have you had any of the following for this problem?

☐CT	☐MRI	☐Bone Scans	☐Occupational Therapy
☐EMG	☐X-Rays	☐Physical Therapy	☐Injections

Who was the doctor ordering these tests [If other than above]? _____

When and where were these treatments done? _____

Did you require surgery for this problem? ☐Yes ☐No

Have you had any previous difficulty or injury to this area? ☐Yes ☐No

If yes, please describe. _____

Primary Care MD? _____ Referring MD [If different]? _____

VITALS

What is your height? _____ What is your weight? _____

PAST MEDICAL HISTORY

Please indicate if YOU have any of the following Problems:

☐ Anesthesia	☐Diabetes	☐TB (Tuberculosis)
☐ Anxiety	☐Seizure Disorder	☐COPD/Emphysema
☐Arthritis	☐Hepatitis A	☐Lupus
☐Anemia	☐Hepatitis B	☐Stomach Ulcers
☐Asthma	☐Hepatitis C	☐Rheumatoid Arthritis
☐Autoimmune	☐High Blood Pressure	☐Thyroid Disease
☐Birth Defect	☐High Cholesterol	☐GERD/Heartburn
☐Bleeding Disease	☐Reflux	☐HIV
☐Depression	☐Kidney Disease	☐Heart Disease/Heart Attack
☐Blood Clots	☐Osteoporosis	☐Other Illness: _____
☐Bruise easily	☐Fibromyalgia	☐NONE

Cancers:

☐Brain	☐Lung	☐Prostate	☐Cervical
☐Breast	☐Liver	☐Skin	☐Other Cancer:
☐Colon/Rectal	☐Ovarian	☐Stomach	☐NONE

Items not checked are understood to be negative

SURGERIES

Please list any surgeries you have had and their approximate date: _____

_____

☐ I have had no surgeries

FAMILY HISTORY

Please indicate if your parents or grandparents have had any of the following:

☐Anesthesia Problems ☐Arthritis ☐Heart Disease ☐Bleeding Disease ☐Birth Defects ☐NONE Not

SOCIAL HISTORY

Occupation: _____ Handedness: ☐Right ☐Left ☐Ambidextrous (Both)

Who are you living with? (Mark ALL that apply).

☐Spouse/Partner ☐Parents ☐Friends ☐Nursing Home

☐Alone ☐Siblings ☐Children ☐In Retirement Community

How many children do you have? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5+

What is your current smoking status? ☐Current ☐Previous ☐Never

What type of tobacco use: ☐Cigarettes ☐Cigars ☐Smokeless/Chew ☐Pipe How many/day (packs-if cigarettes): ___

If you quit, when did you quit? _____

Do you drink alcohol? ☐Yes ☐No If yes, drinks per week: ___ Type(s) of Alcohol: _____

Do you exercise? ☐Yes ☐No If yes, how often: ☐1-3 times a week ☐3-5 times a week ☐Daily

Please list any other medical problems: _____

MEDICATIONS

Please list current medications and doses. Include Prescriptions, Over-the-Counter, Herbal & Supplements [Attach list, if available].

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Do you have any medication allergies? ☐Yes ☐No If yes, list medication and reaction:

Medication: _____

Reaction: ☐Rash/Hives ☐GI Upset ☐Anaphylactic Severity: ☐Mild ☐Moderate ☐Severe ☐Critical

Medication: _____

Reaction: ☐Rash/Hives ☐GI Upset ☐Anaphylactic Severity: ☐Mild ☐Moderate ☐Severe ☐Critical

Medication: _____

Reaction: ☐Rash/Hives ☐GI Upset ☐Anaphylactic Severity: ☐Mild ☐Moderate ☐Severe ☐Critical

Patient's Signature_____ Date: _____

Arkansas Orthopedics and Sports Medicine, P.A.

Dr. Tarik Sidani, D.O.
Dr. Justin Cutler, D.O.
Dr. Brian Linn, M.D.

Medical Information Release Form

(HIPPA Release Form)

Name:_____ DOB_____
(printed name)

Release of Information

[ ] I authorize the release of my medical information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

OR

[ ] Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell

If unable to reach me:

[ ] you may leave a detailed message.

[ ] please leave a message asking me to return your call.

[ ] _____

The best time to reach me is:_____

Signed: _____ Date _____

Witness:_____ Date_____

224 West Erie, Harrison, AR 72601 • Phone (870) 741-8289 • Fax (870) 741-0308

Arkansas Orthopedics and Sports Medicine, P.A.

Dr. Tarik Sidani, D.O.
Dr. Justin Cutler, D.O.
Dr. Brian Linn, M.D.

Guarantor's Statement

I hereby request and authorize my insurance company and/or companies to pay directly to Arkansas Orthopedics and Sports Medicine, P.A., 224 West Erie Avenue, Harrison AR 72601 any proceeds payable under the term of my policy and/or policies. This is an irrevocable assignment and I understand and agree any unpaid balance not covered by this policy is my obligation and will be paid my me.

I agree that I will pay the balance in full or agree to pay at lease 15% of the balance on my account on a monthly basis if the balance has not been paid in full thirty (30) days after the insurance has been filed.

_____ _____

Patient/Guarantor's Signature Date

I hereby give my consent to Arkansas Orthopedics and Sports Medicine, P.A. to release my medical information pertaining to my claim to my insurance company and/or companies or my attorney, if applicable, as outlined in Arkansas Orthopedics and Sports Medicine, P.A. Privacy Practices. By signing below, I acknowledge that I have been offered a copy of this notice.

_____ _____

Patient/Guarantor's Signature Date

It is the policy of Arkansas Orthopedics and Sports Medicine, P.A. to help the patient in obtaining full benefits from his/her insurance companies, however, we are not obligated to withhold our billing statement or wait until settlement has been made before receiving payment for our services.

PAYMENT IS DUE UPON RECEIPT OF MONTHLY STATEMENTS.