STEPHEN E. EARLE, MD, PA

CERTIFIED-AMERICAN BOARD ORTHOPAEDIC SURGERY

CERTIFIED-AMERICAN BOARD SPINAL SURGERY

PATIENT: _____ DATE: _____

ADDRESS: _____ CITY _____ STATE: ___ ZIP: _____

HOME PHONE NUMBER: _____ CELL PHONE NUMBER: _____

SOCIAL SECURITY NUMBER: _____-_____-_____ MALE/FEMALE: ___ DATE OF BIRTH: _____

MARITAL STATUS: _____

IF THE PATIENT IS A MINOR, RESPONSIBLE PARTY: _____
RELATIONSHIP TO PATIENT: _____

IN CASE OF EMERGENCY, CONTANT: _____
PHONE NUMBER: _____

ANY KNOWN ALLERGIES: _____

CURRENT EMPLOYER: _____

WORKER'S COMPENSATION PATIENTS, PLEASE CONTINUE TO THE SECTION MARKED 'WORKER'S COMPENSATION.'

PRIMARY INSURANCE COMPANY: _____ ID: _____
MEMBER NAME: _____ GROUP #: _____

SECONDARYINSURANCE COMPANY: _____ ID: _____
MEMBER NAME: _____ GROUP #: _____

WORKER'S COMPENSATION SECTION

IF KNOWN,
DATE OF INJURY: _____ INSURANCE COMPANY: _____
CLAIM #: _____ ADJUSTER: _____

PHONE NUMBER: _____ ADDRESS: _____
NAME OF EMPLOYER (AT THE TIME OF THE INJURY): _____
HOW DID THE INJURY OCCUR: _____

SYMPTOMS:

WHERE IS THE PAIN LOCATED: _____

___CHILLS ___DEPRESSION ___DIZZINESS ___FANITING ___FEVER ___HEADACHE
___ANXIETY ___SLEEP LOSS ___NUMBNESS ___CHEST PAIN ___HIGH BLOOD PRESSURE
___SHORTNESS OF BREATH ___LOW BLOOD PRESSURE ___BLURRED VISION
___DIFFICULTY SWALLOWING ___BURNING SENSATION IN ARMS ___BURNING SENSATION IN LEGS
___BURNING SENSATION IN LEGS ___LOSS OF BLADDER CONTROL

HISTORY:

___PACEMAKER ___AIDS ___ALCOHOLISM ___ANEMIA ___BLEEDING DISORDERS
___EPILEPSY ___HEART DISEASE ___HIV POSITIVE
___LIVER DISEASE ___SEIZURES ___STROKE ___VENEREAL DISEASE

MEDICATIONS:

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

FAMILY HISTORY OF MEDICAL CONDITIONS, IF KNOWN:

_____
_____
_____
_____

SOCIAL HISTORY:

EXERCISE? ____ IF SO, HOW OFTEN? _____
SMOKE? _____ IF SO, HOW OFTEN? _____
ALCOHOL? ___ IF SO, HOW OFTEN? _____

HOSPITALIZATIONS:

IF SO, WHEN, WHERE, WHAT FOR?

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

HAVE YOU EVER HAD A BLOOD TRANSFUSION? _____ WHEN?_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATIONNECESSARY TO THOSE PARTIES DEEMED APPROPRIATE IN CONNECTION WITH MY CARE. I UNDERSTAND THAT CHARGES INCURRED ARE MY DIRECT RESPONSIBILITY (WORKER'S COMPENSATION CASES EXEMPTED.)

DATE _____ **SIGNATURE** _____

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM MY DOCTOR, IF I, OR MY MINOR CHILD, EVER HAS A CHANGE IN HEALTH.

SIGNATURE _____
PRINTED NAME:_____
RELATIONSHIP TO PATIENT, IF NOT SELF: _____
DATE:_____

RELEASE OF INFORMATION-ASSIGNMENT OF BENEFITS

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CO-PAYMENTS, CO-INSURANCE AND/OR DEDCUCTIBLE ASSOCIATED WITH MY INSURANCE COVERAGE AND/OR MEDICAL CHARGERS INCURRED PRIOR TO THE ACTIVIATION OF, OR FOLLOWING TERMINATION OF MY INSURANE COVERAGE.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO MY PHYSICIAN, DR. STEPHEN E. EARLE, M.D.

I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE COMPANY.

I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES.

I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS AND PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PALCE OF THE ORIGINAL.

I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS/STUDIES TO THOSE PHYSICIANS TO WHOM I AM REFERRED.

SIGNATURE_____
PRINTED NAME _____
DATE_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I HAVE RECEIVED THIS OFFICE'S NOTICE OF PRIVACY PRACTICES, WHICH EXPLAINS HOW MY MEDICAL INFORMATION WILL BE USED AND DISCLOSED.

SIGNATURE _____
DATE_____