ENTERED

Jean Yun, M.D.

Orthopaedic Surgery

Date: _____

Patient Information

Patient Name: _____ Age:____ Date of Birth:_____

Social Security: _____ Sex: Male/Female Marital Status:_____

Home Address: _____ Home Phone:_____

_____ Cell Phone: _____

Current Occupation: _____ Employer: _____

Business Address: _____ Business Phone: _____

If Student, Name of School / College : _____ E-mail _____

Name OF Pharmacy: _____ TEL: _____

Emergency Contact (Required): _____Relationship: _____Phone Number: _____

Spouse's /Parent's Name: _____Employer: _____ Phone: _____

DO You have an advance Directive ? Yes /NO Name of Health Agent _____

Family Doctor: _____ Referred By: _____

Has This office previously treated any member of your family: Yes___ No___ Name:_____

Insurance & Payment

Bill will be paid by? Self Insurance Other

Insured's Name: _____ Relationship to Patient: _____

Date of Birth: _____ Business No: _____

Social Security #: _____ Insurance ID #: _____

Referral is required: YES / NO

Medicare, Medicaid, commercial insurance, worker's compensation, auto insurance, No Insurance .

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Past Medical History

Please list all surgeries, illness, and injuries:

_____

_____

Medications:

_____

_____

Health Questions

Yes___ No___ Are you allergic to any drugs or medication?
If yes, what medication and describe the reaction:

_____

Yes___ No ___ Have you ever had a bad reaction to General Anesthesia?

Yes___ No___ Do you have high blood pressure?

Yes___ No___ Do you have diabetes?

Yes___ No___ Do you have a heart condition?

Yes___ No___ Do you bleed unusually easily from cuts or surgery?

Yes___ No___ Do you have a family history of rheumatoid arthritis or lupus?

Yes___ No___ Do you smoke? How much? _____

Yes___ No___ Do you consume alcohol regularly? How Much? _____

Yes___ No___ Is your visit related to an injury at work?

Yes___ No___ Is your visit related to a car accident?

When was your last physical examination? Date: _____BP: _____ Height: _____ Weight: _____
Briefly explain the reason for today's visit.

_____

Yes___ No___ have you seen another orthopaedic surgeon about the SAME problem which brings you here? Comments

_____

I hereby authorize payment to be made directly to Jean Yun, M.D. for any medical or surgical benefits that she may be entitled to under my Medical-Surgical plans. I understand that I am responsible for any balance due for my professional services in excess of the benefits provided by my insurance policy.

I also give permission for the use of any photographs, fluoroscopy, injection or X-rays of this case for medical lectures, publications, or teaching purpose.

I have received information regarding the providers of care in this organization, the grievance process, the patient's Bill of Rights and responsibilities.

_____ _____ _____

Responsible Party / Parent Signature (Print Name) Witness Date

FOR OFFICE USE ONLY

today pain is ___ to 10, Flu, Pneumococcal, Last DEXA _____, ( ) falls in the past year