Patient Personal Information

Full Name:				Date of Birth:	
Address:		City:		State:	Zip:
Sex:	SSN:	Primary Phone:		Martial Status: M / S / D / W	
Place of Employment:		Work Phone:		Cell Phone:	
Responsible Party's Name:		Responsible Party's DOB:		Responsible Party's SSN:	
Parent's Name (if patient is a minor)		Parent's SSN:		Height:	Weight:
Pharmacy:		Driver's License(D.L.) #:	D.L. State	Shoe Size:	
Emergency Contact Name:				Phone #:	

Problem History

In your own words, please describe the problem you are having:

____

____

Mild Pain — Severe Pain

NONE (0) 1 2 3 4 5 6 7 8 9 10

Who is your regular doctor? ____________

Dr. Address ____________ Phone ____________

Who referred you to us? ____________

Social History

Do you smoke? Yes /No How much? ____________

Do you drink alcohol? Yes / No How much? ____________

Occupation: ____________

Medical History

Are you allergic to any medicines (please circle)?

Penicillin Sulfa Codeine Aspirin Adhesive Iodine

Other: ____________

Please list all current medications (& dose) and supplements:

______________ ______________

______________ ______________

______________ ______________

Please list all previous surgeries and hospitalizations:

______________ ______________

______________ ______________

______________ ______________

Medical Review of Systems

Please check (✔) if you or a family member have or have had any of the following:

Condition	Patient	Family
Frequent Headaches		
Frequent Blurred or Double Vision		
Dizziness		
Epilepsy		
Bleeding from the ears or nose		
Ringing in the ears		
Difficulty swallowing		
Thyroid Problems		
Chest Pain / Angina		
Heart Attack/Heart Disease		
High Blood Pressure/Hypertension		
Anemia/Low Blood		
Excessive Bleeding		
Difficulty Breathing/Wheezing/Asthma		
Tuberculosis		
Rheumatic Fever		
Pneumonia		
Stomach Ulcer/Frequent Heartburn		
Colon Disease		
Difficulty going to the Bathroom		
Gallbladder Disease		
Kidney Problems		
Liver Disease or Jaundice		
Hepatitis		
Cancer		
Bone or Joint Disease (Arthritis)		
Bursitis/Sciatica		
Low Back Pain		
Poor Circulation		
Phlebitis or Vein Problems		
Leg or Night Cramps		
Gonorrhea/Syphilis		
Tested Positive for HIV		
Diabetes		

Please list any other medical problems:

FINANCIAL POLICY

We file your insurance. However, you, the patient will be responsible for any balance remaining after insurance payment and any attorney collection fees incurred trying to collect that balance.

I hereby give permission to Dr. Jackson to release any information necessary to collect that balance.

I hereby name as assignee and also instruct my insurance carrier to pay by check made out and mailed to **Brian D. Jackson, DPM, LLC, 1215 Hatcher Lane, Columbia, TN 38401**

I agree that a photocopy of this assignment shall be considered as effective as the original.

Thank you! Dr. Brian Jackson & Staff

Signature ______________________ Date ______________