

ARMSTRONG ORTHOPEDIC ASSOCIATES LLC
BERT C. HEPNER, D.O.
316 FIRST AVENUE, SUITE 275
KITTINGING, PA 16201

PATIENT INFO & MEDICAL HISTORY

PATIENT FULL NAME: _____

PARENT OR GUARDIAN (if patient is a minor): _____

PATIENT ADDRESS: _____

HOME PHONE: _____ CELL/WORK PHONE: _____

DATE OF BIRTH: _____ AGE: _____ SEX: MALE FEMALE

HEIGHT: _____ WEIGHT: _____ NAME OF SPOUSE &
MARITAL STATUS: _____

SOCIAL SECURITY NO.: _____

PATIENT/PARENT EMPLOYER: _____

EMPLOYER ADDRESS & PHONE: _____

EMERGENCY CONTACT NAME & PHONE NO.: _____

FAMILY & CURRENT/PREVIOUS TREATING
PHYSICIANS: _____

WERE YOU REFERRED TO OUR PRACTICE? _____ BY WHOM? _____

REASON FOR TODAY'S VISIT: _____

HAVE YOU HAD RECENT X-RAYS: YES NO
IF YES, WHERE? _____

OCCUPATION & JOB DUTIES: _____

LIST ANY OTHER PAST OR PRESENT PROBLEMS THAT YOU HAVE BEEN
TREATED FOR (including surgeries & injuries): _____

ANY KNOWN ALLERGIES: _____

LIST ALL PRESCRIPTION & OVER THE COUNTER MEDICATIONS: _____

PLEASE CHECK YES OR NO, AND LIST TYPE OF PROBLEMS.
PLEASE DO NOT LEAVE ANY BLANK.

	YES	NO	
CHILLS/FEVER	_____	_____	
WEIGHT CHANGE	_____	_____	LOSS or GAIN (CIRCLE ONE)
HEADACHES	_____	_____	
DIZZINESS	_____	_____	
EPILEPSY	_____	_____	
CONVULSIONS	_____	_____	
PARALYSIS	_____	_____	
EYE PROBLEMS	_____	_____	
PHLEBITIS/DVT/ BLOOD CLOTS	_____	_____	
CANCER	_____	_____	
SHORTNESS OF BREATH	_____	_____	WHAT _____
ASTHMA	_____	_____	
EMPHYSEMA	_____	_____	
PNEUMONIA	_____	_____	
ARTHRITIS	_____	_____	
STROKE	_____	_____	
HARDENING OF THE ARTERIES/PVD	_____	_____	
JOINT PAIN	_____	_____	
FAINTING	_____	_____	
RHEUMATIC FEVER	_____	_____	
HEART PROBLEMS	_____	_____	TYPE _____
GALLBLADDER	_____	_____	
NAUSEA	_____	_____	
LIVER PROBLEMS	_____	_____	TYPE _____
APPETITE CHANGES	_____	_____	
HEARTBURN	_____	_____	
ULCER	_____	_____	WHEN _____
BOWEL PROBLEMS	_____	_____	TYPE _____
PROSTATE PROBLEMS	_____	_____	
URINARY PROBLEMS	_____	_____	TYPE _____
DIABETES	_____	_____	HOW LONG _____
VENERAL DISEASE	_____	_____	
BLEEDING DISORDER	_____	_____	
PACEMAKER	_____	_____	

HOW MUCH CAFFEINE DO YOU CONSUME IN ONE DAY? _____
COFFEE TEA SODA POP

DO YOU USE TOBACCO PRODUCTS? YES NO
CIRCLE ALL THAT APPLY: CIGARETTES CIGARS CHEWING TOBACCO
HOW MUCH PER DAY? _____ FOR HOW LONG? _____

DOES ANYONE IN YOUR HOUSEHOLD SMOKE? YES NO
IF YES, WHO AND HOW MUCH? _____

DO YOU DRINK ALCOHOLIC BEVERAGES? YES NO
HOW MUCH PER DAY? _____ TYPE OF BEVERAGE? _____

SOCIAL OR INTRAVENOUS DRUGS? PAST OR PRESENT

DO YOU HAVE A HIGH STRESS LEVEL? YES NO
WHY? _____

***** FAMILY MEDICAL HISTORY *****

ANY KNOWN DISEASES THAT RUN IN YOUR FAMILY? _____

MOTHER: _____

FATHER: _____

BROTHERS/SISTERS: _____

ARE YOUR PARENTS LIVING?

MOTHER: YES NO

FATHER: YES NO

IF NOT, CAUSE(S) OF DEATH: _____

INSURANCE INFORMATION SHEET

PLEASE CIRCLE THE INSURANCE THAT APPLIES:

MEDICARE BLUESHIELD HMO WORKER'S COMP AUTO MEDICAID OTHER

NAME OF POLICY OWNER: _____

ADDRESS OF POLICY OWNER: _____

PHONE & BIRTHDATE OF POLICY OWNER: _____

SS# OF POLICY OWNER: _____

EMPLOYER OF POLICY OWNER: _____

POLICY OWNER'S RELATIONSHIP TO PATIENT _____

DATE OF ACCIDENT FOR AUTO OR W/C _____

POLICY OR CLAIM # _____

PLEASE PRESENT YOUR INSURANCE CARD TO RECEPTIONIST TO COPY - THANK YOU

If surgery is indicated, the patient is responsible for furnishing insurance forms to the office prior to surgery.

AUTHORIZATION:

I hereby authorize Dr. Bert Hepner, to furnish information to my insurance carrier concerning my illness and treatments, and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

SIGNATURE: _____ DATE: _____

Parent or legal guardian please sign if patient is under 18 years of age.

MEDICARE AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries of carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party accepting assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

SIGNATURE: _____ DATE: _____

I authorize any holder of medical or other information about me to release to _____ any information needed for this or a related Medigap claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

SIGNATURE: _____ DATE: _____