Daniel C. Eby D.O. PC
Orthopedic Surgery & Sports Medicine
600 W. 13th St. Suite 200 • Jasper, IN 47546

Initial/Yearly Form

PATIENT INFORMATION

Email: _____
Cell Phone: _____
Patient's Name (Last/First/MI): _____ Age: _____ Birthdate: _____
Street Address: _____ City & State: _____ Zip Code: _____
Patient's Social Security Number: _____ Patient's Home Number: _____
Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced Sex: ❑ Male ❑ Female
Are you currently employed? ❑ YES ❑ NO ❑ Retired ❑ Disabled ❑ Student
Employer's Name/Address: _____
Job Description: _____ Employer's Phone Number: _____
Family Physician/Address: _____ Physician Phone Number: _____
Referred By: _____ Preferred Pharmacy: _____
Spouse's Name: _____ Spouse's Phone Number: _____
Spouse's Social Security Number: _____ Date of Birth: _____
Spouse's Employer/Address: _____

MEDICAL HISTORY

Reason for office visit: _____ ❑ LEFT SIDE ❑ RIGHT SIDE
Date symptoms began: _____ Did this occur at work? ❑ YES ❑ NO
If not at work, where did injury occur? _____

HEALTH HISTORY

Drug/Medicine/Allergies/Type of reaction: _____
List current medications: _____
Date of last tetanus shot/immunizations: _____
Previous surgeries: _____
Fractures or hospitalizations: _____
Have you ever been treated for gastric (stomach) ulcers? ❑ YES ❑ NO
Have you ever had: ❑ Blood Clots (year____) ❑ Heart Attack (year____) ❑ Stroke ❑ Heart Failure ❑ High blood pressure
❑ Ankle swelling ❑ Kidney failure ❑ Cancer (location_____) ❑ Upset Stomach while taking anti-inflammatories
If so, which ones (Aleve/Advil/etc.) _____
Do your other joints have: ❑ Morning stiffness lasting over 30 minutes ❑ Joint pain or swelling ❑ Back Pain ❑ Gout
❑ Rheumatoid arthritis ❑ Osteoporosis ❑ Prior Fracture (which bone) _____
Do you have a latex allergy? ❑ YES ❑ NO Are you taking blood thinner: ❑ YES ❑ NO Which one: _____
Have you or a family member ever had a reaction to anesthesia? ❑ YES ❑ NO
Height: _____ Weight: _____ Dominant Hand: ❑ RIGHT ❑ LEFT

PATIENT'S HEALTH PROBLEMS (Please check all that apply)	**YEAR**	**Details/Comments**
Have you had any of the symptoms?		
GI ❑ Heartburn ❑ Ulcers ❑ Nausea/Vomiting	_____	_____
❑ Blood in stool ❑ Hepatitis ❑ Liver disease	_____	_____
ENDO ❑ Thyroid Disease ❑ Heat or Cold Intolerance	_____	_____
CON ❑ Weight Loss ❑ Loss of Appetite	_____	_____
EYE ❑ Blurred Vision ❑ Double Vision ❑ Vision Loss	_____	_____
ENT ❑ Hearing Loss ❑ Hoarseness ❑ Trouble Swallowing	_____	_____
CV ❑ Chest Pain ❑ Palpitations	_____	_____
RS ❑ Chronic Cough ❑ Shortness of breath	_____	_____
GU ❑ Painful Urination ❑ Blood in urine ❑ Kidney Problems	_____	_____
SK ❑ Frequent Rashes ❑ Skin Ulcers ❑ Lumps ❑ Psoriasis	_____	_____
NEU ❑ Headaches ❑ Dizziness ❑ Seizures	_____	_____
PSY ❑ Depression ❑ Drug/Alcohol Addiction ❑ Sleep Disorder	_____	_____
HEM ❑ Easy Bleeding ❑ Easy Bruising ❑ Anemia	_____	_____

FAMILY HISTORY

Have any direct relatives had any of the following disorders? If so, which relative?
❑ Diabetes _____ ❑ High Blood Pressure _____ ❑ Rheumatoid Arthritis _____ ❑ NONE
Do any direct relatives have the same condition you are being seen for today? ❑ YES ❑ NO If so, who: _____

SOCIAL HISTORY

Hobbies/Sports: _____
Do you use alcohol? ❑ YES ❑ NO If "YES", do you use alcohol: ❑ DAILY ❑ WEEKLY ❑ OCCASIONALLY
Do you smoke? ❑ YES ❑ NO If "YES", what do you smoke: ❑ CIGARETTES ❑ CIGARS ❑ PIPE TOBACCO ❑ OTHER
How often do you smoke? ❑ DAILY ❑ WEEKLY ❑ OCCASIONALLY

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FINANCIAL INFORMATION

IF CHILD:

Father's Name: _____ Address: _____
Home Phone: _____ Work Phone: _____ Social Security Number: _____
Employer: _____ Occupation: _____ Date of Birth: _____
Employer Address: _____ City & State: _____ Zip Code: _____

Mother's Name: _____ Address: _____
Home Phone: _____ Work Phone: _____ Social Security Number: _____
Employer: _____ Occupation: _____ Date of Birth: _____
Employer Address: _____ City & State: _____ Zip Code: _____

FINANCIAL INFORMATION
Name of individual responsible for this account: _____ Relationship: _____
Address: _____ City & State: _____ Zip Code: _____
Telephone Number (Home): _____

EMERGENCY INFORMATION (Person to contact in case of emergency, not currently living with you)
Name of individual to contact in an emergency: _____ Relationship: _____
Address: _____ City & State: _____ Zip Code: _____
Telephone Number (Home): _____ Telephone Number (Work): _____

PLEASE READ & SIGN

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, of Healthcare Operations.

I understand that as part of my health care, Dr. Daniel C. Eby, DO, originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I am financially responsible for any charges not covered by my insurance company.

I understand I will be charged a $40 fee for any no show appointments if I do not call and cancel prior to my scheduled appointment time.

PLEASE HAVE ALL INSURANCE CARDS READY TO BE COPIED

_____
Patient Signature

_____
Date

_____
Parent's Signature (if applicable)

_____
Date