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

PATIENT INFORMATION

Patient's Name (Last/First/MI): ____________________ Age: __________ Birthdate: __________________

Marital Status: Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated ❑ Sex: Male Female

Street Address: ____________________ City & State: ____________________ Zip Code: __________________

Patient's Social Security Number: ____________________ Patient's Home Phone Number: ____________________

Are you currently employed? YES ❑ NO ❑ Retired ❑ Disabled ❑ Student ❑

Employer's Name/Address: ____________________

Job Description: ____________________ Employer's Phone Number: ____________________

Employer Contact Person: ____________________

Family Physician: ____________________ Referred By: ____________________

INJURY INFORMATION

Is this condition related to your employment? YES ❑ NO ❑

Reason for office visit: ____________________ ❑ LEFT ❑ RIGHT

Date of accident/illness: __________________ Time of accident/illness: _______________

How did the injury/illness occur? ____________________

Date of first treatment: ___________________ Attending Physician: ____________________

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

If "YES", how often do you smoke? ❑ DAILY ❑ WEEKLY ❑ OCCASIONALLY

Has Dr. Daniel Eby treated anyone in your family? YES ❑ NO ❑ If so, who: ____________________

PAIN

Do you have pain now? YES ❑ NO ❑ Location of pain: ____________________

What increases your pain? ____________________

What decreases your pain? ____________________

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 ❑

PATIENT'S HEALTH PROBLEMS (Please check all that apply) (List specifics pertaining to cancer, heart & emotional problems)

Seizures ❑	Kidney Disease ❑	Diabetes ❑	Other ❑	____________________
Arthritis ❑	Gout ❑	Asthma ❑	Cancer ❑	____________________
Hypertension ❑	Back Problems ❑	Respiratory ❑	Heart ❑	____________________
(High Blood Pressure)	Neuromuscular ❑	Autoimmune Disease ❑	Emotional ❑	____________________

Height: ____________________ Weight: _________________ Dominant Hand: ❑ RIGHT ❑ LEFT

(over)

WCOMP

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EMPLOYER INFORMATION

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

In the event I fail to properly complete the claim for Workman's Compensation for this injury/illness/condition, or it is determined by the Workman's Compensation Board that the injury/illness/condition is not a result of a compensable Workman's Compensation case, I hereby agree to pay the physician's usual and customary fee for services rendered to the above named claimant in the above identified case.

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

____
Patient Signature

____
Date

OFFICE USE ONLY

EMPLOYER INFORMATION
Workman's Compensation Carrier (Insurance Company Name): ____
Insurance Company Address: ____________________________________ City & State: _________________________ Zip Code: ________________
Insurance Company Telephone Number: ___________________________ Fax Number: ________________________
Case Manager: ____ Case Manager Telephone Number: ________________________________
Adjuster's Name: ____ Claim Number: ____