Arthritis Consultants, P.A.
Jeffrey W. Jundt, M.D.

PATIENT REGISTRATION

Patient Name: ______________________________________ Date of Birth: ____________ Sex: M __ F __ SS#: ______________

Street Address: ____ City: ________________ State: _______ Zip: _______

Home Phone: ____ Work Phone: ____

Employer: ____ Occupation: ____

Employer Address: ____ City: ________________ State: _______ Zip: _______

Spouse's Name: ____________________________________ Spouse's Date of Birth: ____________ SS# ___________________

Spouse's Employer:__________________________________ Occupation:_____________________ Work Phone: ____________

Employer Address: ____ City: ________________ State: _______ Zip: _______

Emergency Contact: _____________________________________ Phone #: __________________ Relationship: ____________

Requesting Provider: ____ Phone #: ____

Provider's Address: ____ City: ______________ State: _______ Zip: _______

INSURANCE & RESPONSIBLE PARTY INFORMATION (PAYMENT DUE AT TIME OF SERVICE)

Primary Insur. Company: _______________________________ Phone #: __________________ Effect. Date: ________________

Insur. Address: ____ City: __________________ State: ______ Zip: _________

Name of Insured: ____ Relation to Patient: ___________________________________

ID#: ____ Group #: ____

Additional Insur. Company: ______________________________ Phone #: __________________ Effect. Date: _______________

Insur. Address: ____ City: __________________ State: ______ Zip: _________

Name of Insured: ____ Relation to Patient: ___________________________________

ID#: ____ Group #: ____

ASSIGNMENT OF INSURANCE BENEFITS – MEDICARE/MEDICAID

I hereby authorize direct payment of medical/surgical benefits to Dr. Jeffrey W. Jundt, for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize Dr. Jeffrey W. Jundt, to release any medical information that may be necessary for either medical care or in processing applications for financial benefit.

I certify that the information given by me in applying for payment is correct. I authorized release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

Signature: ____ Date: ______________

**************Office Policies******************

1. **ALWAYS bring insurance cards, picture identification and any previous/new records to all visits**
2. **ALL fees/co-pays/deductibles are due at time of appointment. NO EXCEPTIONS**
3. **There will be a $25.00 fee if you do not cancel a return appointment 24 hours in advance. New patient no-show fees are $50.00. That time is reserved for you and no one else.**
4. **No children permitted unless they have an appointment.**
5. **No food or drinks permitted in clinic. Please silence/turn off all cell phones while in exam room.**
6. **Arrive about 15-20 minutes prior to appointment to ensure all information has been checked and completed from your insurance company, outside labs/x-ray, other physicians, pharmacies, etc.**

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HISTORY OF PRESENT ILLNESS

Date: ______________________

Patient Name: ______________________________________ DOB: _________________ Age: _______ Sex: M ___ F ___

Reason for visit:

____

____

Please describe symptoms:

____

____

____

____

REVIEW OF SYSTEMS

Systems	**Please circle any that applies to you:**
Constitutional Symptoms	1. Fever 2. Weight Change (gained_______ lost_______) 3. Fatigue
Eyes	4. Blurring 5. Double Vision 6. Dry Eyes 7. Recurrent Redness 8. Light Sensitivity
Ears, Nose, Throat & Mouth	9. Deafness 10. Dizziness 11. Sinus Congestion 12. Dry Mouth 13. Mouth Ulcers
Cardiovascular	14. Chest Pain 15.Palpitations 16. Irregular Beats 17. High Blood Pressure
Respiratory	18. Shortness of Breath 19. Wheezing Cough 20. Blood in sputum 21. Painful Breathing
GI	22. Appetite change 23. Difficulty Swallowing 24. Abdominal Pain 25. Diarrhea 26. Constipation 27. Blood in Stool 28. Hemorrhoids
GU	29. Loss of Bladder Control 30. Difficulty Urinating 31. Burning while Urinating 32. Blood in Urine 33. Kidney Stones
Musculoskeletal	34. Fractures 35. Sprains 36. Painful Joints 37. Swollen Joints 38. Joint Stiffness
Skin	39. Rashes 40. Color Changes 41. Skin Ulcers 42. Knots/ Skin Nodules
Neuro	43. Weakness 44. Numbness 45.Tingling 46. Seizures 47. Memory 48. Coordination Problem
Psychological	49. Depression 50. Mood Swings 51. Sleep Disturbances
Endocrine	52. Excessive Hunger or Thirst or Urination 53. Change in Hair Growth (loss or gain)
Hematologic/Lymphatic	54. Anemia 55. Bleeding Tendency 56. Lymph Node Pain/Enlargement
Allergic/Immunologic	57. Hives 58. Eczema 59. Itching

☐ All unmarked systems are unremarkable.

DOCTORS comments only:

____

____

____

____

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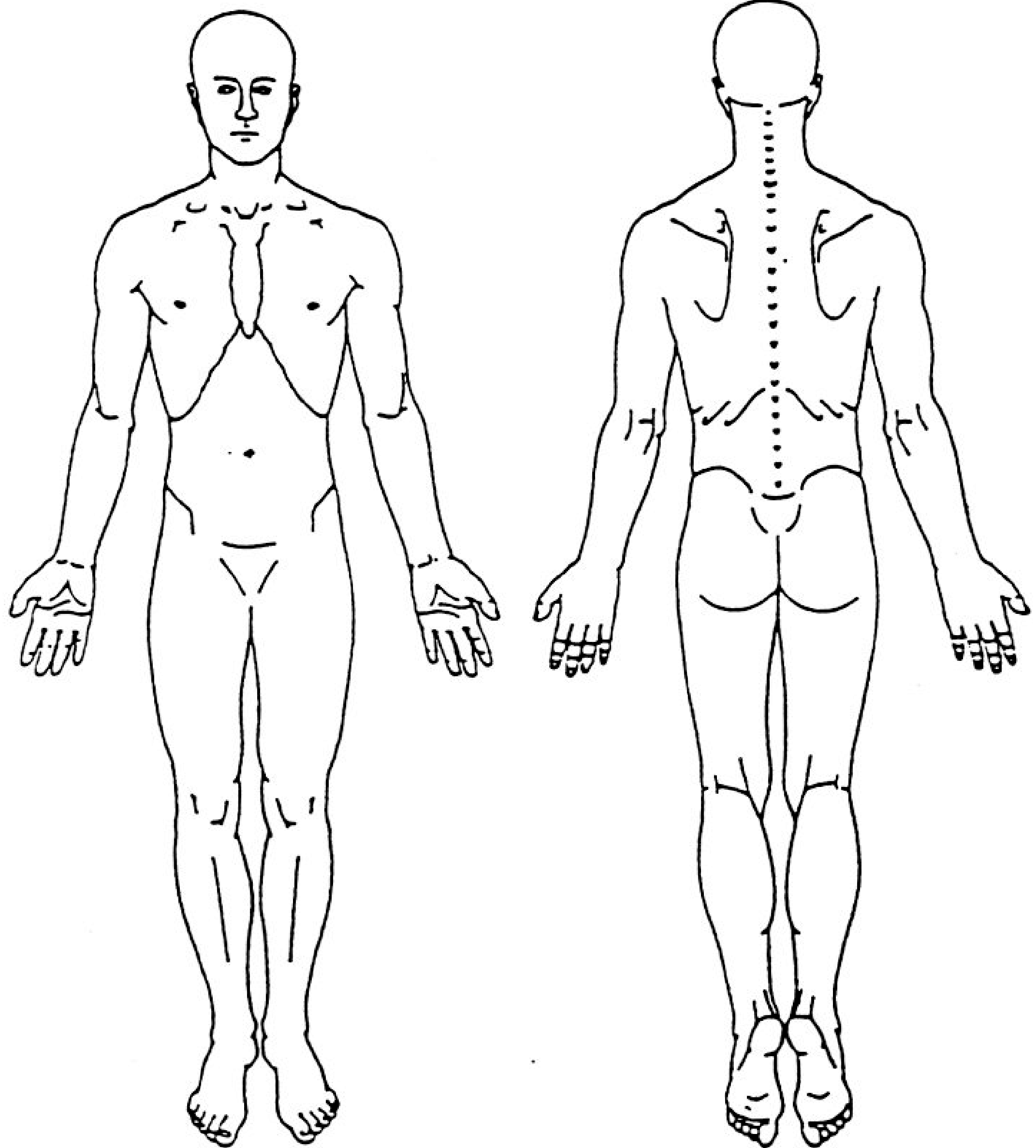
PAIN DIAGRAM

Date: ______________________

Patient Name: _______________________________________ DOB: ______________ Age: _______ Sex: M ___

PAIN SCALE AT THIS TIME: (please circle) 0 1 2 3 4 5 6 7 8 9 10 (10 is worst pain in your life)

Please put an X in the most severe, painful area, all aching with OOOO and sharp/burning with//////:



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PAST MEDICAL HISTORY

Date: ______________________

Patient Name: _______________________________________ DOB: ______________ Age: _______ Sex: M ___ F ___

To receive the service you deserve from Dr. Jundt your Medical History is Essential**.**

PERSONAL PAST HISTORY **(have you suffered from any of the following?)**

Condition	Date Onset	Active/ Inactive	Condition	Date Onset	Active/ Inactive	Condition	Date Onset	Active/ Inactive
Cerebral Palsy			Thyroid problems			Bleeding Trouble		
Stroke/Nerve Disorder			Stomach Ulcer			Infections		
Cancer			Rheumatic Fever			Hi Blood Pressure		
Colon Trouble			Blood Transfusions			Migraine Headaches		
Lung Problems			Diabetes			Tuberculosis		
Heart Trouble/Attack			Anemia			AIDS/HIV Exposure		
Kidney Trouble			Other					

SURGICAL PROCEDURES OR INJURIES:

Surgery	Place & Date	Doctor

FEMALE: # of Pregnancies: ____ Miscarriages: ____ Living Children: ____ Boys: ____ Girls: ____

Date of Last Menstrual Period: ______________________
ARE YOU OR COULD YOU BE PREGNANT NOW? YES ___ NO ___

FAMILY HISTORY (check the box if any blood relatives have had the following)

√	Condition	√	Condition	√	Condition	√	Condition
	High Blood Pressure		Thyroid problems		Bleeding Trouble		Diabetes
	Stomach Ulcer		Epilepsy or Fits		Cancer		Kidney Trouble
	Eating Disorders		Heart Trouble/ Attack		Depression		Tuberculosis
	Migraine Headaches		Colon Trouble		Arthritis		Autoimmune Disorders

SOCIAL HISTORY: Married ___ Divorced ___ Widowed ___ Single ___ Separated ___

Do you live with? Family ___ Friend ___ Alone ___ How many people live in the home? _________

Do you smoke? YES ___ NO ___ What? ______________________ How much? _____________

Alcoholic Beverages? YES ___ NO ___ What? ______________________ How much? _________

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MEDICATION LIST

Patient Name:________________________________ DOB:_______________ AGE:_____ Sex: M___F___

Drug Allergies:____

Pharmacy #1:___________________________________city:___________telephone:___________________

Pharmacy #2:___________________________________city:___________telephone:___________________

Pharmacy (mail order):____telephone:___________________

MEDICATION NAME and DOSE	Times per day	Date First Prescribe		1st line only: Refill dates—mm/dd/yr 2nd line : Amt+# of refills/F= fax E= eRx T=tele. 0=office 3rd line : any change in dosing				