Jason Butler, M.D. | **Mark Dirnberger, D.O., P.A** | **Thomas Hong, D.O.**

Welcome!

Patient Information:

Name _____ **Date** _____

DOB _____ **Age** _____ SS#: _____

Address: _____
City: _____ State: _____ Zip Code: _____
Home #: _____ Cell #: _____
Emergency Contact: _____ Phone #: _____
Work #: _____ Referred By: _____

Insurance Information:

Primary Insurance Co: _____
Member ID: _____ Group #: _____
Claim#: _____ Adjustor: _____ Phone#: _____
Policy Holder: _____ SS#: _____ Date Of Birth: _____

Secondary Insurance Co: _____
Member ID: _____ Group #: _____
Claim#: _____ Adjustor: _____ Phone#: _____
Policy Holder: _____ SS#: _____ Date Of Birth: _____

Attorney: _____ Contact: _____ Phone#: _____

I hereby instruct and direct my health insurance company, personal injury protection insurance company, and/or my attorney to pay by check made out and mailed to Dr. Mark Dirnberger for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered by this office. I agree to be financially responsible for all charges incurred at this office including my insurance deductible, co-payment, and services rejected by my insurance company, workers compensation insurance, and/or my attorney.

Signature _____ Date: _____

2001 S. E. Green Oaks Blvd #130
Tel: (817) 419-6111 Fax: (817) 419-9582

Notice & Acknowledgement

I acknowledge that I have received the attached Notice of Privacy Practices:

_____ _____

Patient Or Personal Representative Signature Date

_____

Print Name

Authorization Of Release Of Protected Health Information To Family Members

I authorize Dr. Mark Dirnberger to release protected health information to my family member(s) listed below:

Name:	**Relationship:**	**Phone#:**

Office Policies

- A $30.00 fee will be assessed for returned checks.
- If copies of your medical records are needed, the first copy will be free and additional copies after that will have a fee.
- We require 24-hour notification if you are unable to come for any type of office visit or procedure.
- As a courtesy, we call to remind you of your appointment one day in advance. However you are still responsible for the appointment, even if we are unable to contact you. We understand that unforeseen events can occur such as illness or emergencies, but kindly give us a call if you're unable to keep your appointment time.

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Medical History Form

Name _____ **DOB** _____ **Age** _____ **Male/Female**

Medications Currently Taking (Please include all prescriptions, over-the-counter, vitamins, and supplements)

NAME OF MEDICATION	DOSAGE OF MEDICATION

ALLERGIES to any medications, x-ray dyes or other substance Yes or No
(If yes, please list name of medication and type of reaction)

_____

_____

_____

_____

SURGERIES/HOSPITALIZATIONS

Date	Details

SEVERE INJURIES

Date	Details

PAST MEDICAL HISTORY

(Circle or write in Other section for each section)

Neurologic (Nerve or Brain) – Headaches, Migraines, Concussion, Seizures, Stroke, Multiple Sclerosis
Other - _____

Heart / Cardiac - Abnormal EKG, Heart disease, High blood pressure, High cholesterol, Chest Pain, Heart Attack, CHF
Other - _____

Blood Disorder – Anemia, Sickle cell disease, Bleeding disorders, Blood Clots, Blood transfusion
Other - _____

Lung / Pulmonary – Allergies, Asthma, Emphysema, COPD, Home Oxygen
Other - _____

Gastrointestinal - Acid reflux, Ulcers, Colitis, IBS, Constipation, Liver disease, Pancreatitis, Hemorrhoids
Other - _____

Urological – Infections, Kidney stones, Kidney Disease, Dialysis
Other - _____

Autoimmune – Lupus, Rheumatoid, Sjogrens, Celiac,
Other - _____

Endocrine – Diabetes, Hypothyroid, Hyperthyroid, Parathyroid, Low Testosterone,
Other - _____

Musculoskeletal – Arthritis, Gout, Muscle disease, Skeletal disase, Osteoporosis
Other - _____

Psyciatric – Depression, Anxiety, Bipolar, Panic attacks, Insomnia, Alcoholism, Drug Abuse, Suicide attempt
Other - _____

Infectious – Cellulitis, HIV/AIDS, Meningitis, Hepatitis, STD, TB, Lyme
Other - _____

Skin – Eczema, Psoriasis, Shingles, Herpes, Keloid
Other - _____

Cancer – Skin, Blood, Thyroid, Bone, Lung, Prostate, Bladder, Kidney, Colon, Rectal, Breast, Uterine, Ovarian, Cervical
Other - _____

SOCIAL HISTORY

Occupation _____ Employer _____
Marital Status _____ Legal Troubles _____
Do you smoke or use other tobacco products? Yes or No If yes, how much? _____
Do you drink alcohol? Yes or No If yes, how much? _____
Do you use recreational drugs Yes or No What types? _____

FAMILY HISTORY

Condition	Father	Mother	Sibling
Seizure Disorder			
Stroke			
Heart disease			
Hypertension			
High cholesterol			
Heart Attack			
Diabetes			
Bleed/Clotting Disorder			
Anemia			
Asthma			
COPD			
Colon/Bowel problems			
Kidney disease			

Condition	Father	Mother	Sibling
Lupus			
Rheumatoid			
Thyroid Disease			
Arthritis			
Osteoporosis			
Depression/Anxiety			
Suicide			
Drug/alcohol addiction			
Infectious disease			
HIV/AIDS			
Skin disease			
Cancer			
Other			

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Personal Injury Intake Form

Name: _____ Date: _____

Please describe details of the accident: (Circle the Underlined answers when appropriate):

Date of accident - _____ Position in car - Driver or Passenger - Front, Middle, or Back Seat

Location - City Street, Highway, Interstate, or Other _____ Seat Belt – Yes or No

Make/Model - your car _____ other car _____

Type of accident - Head-on, Rear-ended, T-boned, or Other _____ while - Stopped or Moving

Please describe the damage to your car - _____

_____

Did Airbags deploy – Yes or No - Front or Side Was it - Drivable or Towed

Did you see it coming - Yes or No Did you brace for impact - Yes or No

Describe body position at moment of impact - facing forward, twisted left or right, laying down, asleep, or Other

_____

Did you lose consciousness - Yes or No Were you dazed or shaken up - Yes or No

Did Police, Fire, or Ambulance show up - Yes or No Did you get out - on own, with help, or extracted

Did you go to ER by ambulance Yes or No Were you in a Neck Brace and on Backboard - Yes or No

Please describe any pains or other symptoms you felt immediate after accident _____

_____

_____

_____

Did you go to ER or Urgent Care on your own - Yes or No

Date _____ Name _____ Location _____

Did you have - Labs, X-rays, CT scan, MRI Any prescriptions - Yes or No - _____

What was your diagnosis _____

Have you seen any other doctors for this accident, - Yes or No

Dates _____ Name _____ Phone number _____

Dates _____ Name _____ Phone number _____

Dates _____ Name _____ Phone number _____

Did you have any more - Labs, X-rays, CT scan, MRI, or Other _____

Have you had any Chiropractic or Physical Therapy - Yes or No

Dates _____ Name _____ Phone number _____

Have you had any pain injections - Yes or No

Type _____ Doctor who performed _____

Please provide any other details you can about the accident that are not already listed above

_____

_____

Work History

Occupation _____ Employer _____

Describe your normal job functions _____

Are you able to perform your normal job duties - Yes or No

Does your employer have light duty - Yes or No Have you missed time from work - Yes or No

Past History

Have you had any prior Accidents - Yes or No

Date _____ Brief Details _____

Date _____ Brief Details _____

Did you sustain injuries - Yes or No - _____ Were you treated - Yes or No

Have you had any other prior injuries, pains, or symptoms similar to those you sustained in this accident - Yes or No

_____

_____

Do you have a Primary Care Physician - Yes or No

Name _____ Phone number _____

Current Symptoms

Please describe any current body injuries or pains with regard to the following areas:

Head / Face	_____	Abdomen	_____
Neck	_____	Pelvis	_____
Shoulders	_____	Hips	_____
Arms	_____	Legs	_____
Chest	_____	Knees	_____
Mid-Back	_____	Feet	_____
Low Back	_____	Skin	_____

Using the symbols given below, mark the area on your body where you feel the described sensation.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
ΔΔΔΔ	= = = = =	OOOO	XXXX	///////	.....