KRAIG R. PEPPER, D.O. P.A.

6049 South Hulen Street
Suite 101
Fort Worth, Texas 76132
Phone (817)632-0020 Fax (817)632-0022

Thank you for choosing Dr. Kraig Pepper, D.O. P.A. for your care. The following is required to provide you with the quality medical care. The doctor and staff will review this information and place it in your chart.

Today's Date:

LAST NAME:	**FIRST NAME: MI:**
SEX (please circle): MALE FEMALE	**DATE OF BIRTH:**
SOCIAL SECURITY #:	**DRIVERS LICENSE #:**
ADDRESS:	**HOME PH:**
CITY:	**WORK PH:**
STATE: ZIPCODE:	**CELL PH:**
EMAIL:	**MARITAL STATUS:**

EMPLOYER:		
ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**

RESPONSIBLE PARTY:		
RELATIONSHIP:		
HOME PH:	**WORK PH:**	**CELL PH:**

PRIMARY CARE DOCTOR:	**PHONE:**
WHO REFERRED YOU:	**PHONE:**
EMERGENCY CONACT:	**PHONE:**

Insurance Information

*****If Workers Comp, please request a claim form from the front desk. *****

PRIMARY INS CARRIER:	**POLICY HOLDER:**
POLICY ID:	**GROUP:**
RELATIONSHIP TO INSURED:	**INSURED'S EMPLOYER:**
INSURED'S SOCIAL SECURITY:	**INSURED'S DATE OF BIRTH:**

SECONDARY INS CARRIER:	**POLICY HOLDER:**
POLICY ID:	**GROUP:**
RELATIONSHIP TO INSURED:	**INSURED'S EMPLOYER:**
INSURED'S SOCIAL SECURITY:	**INSURED'S DATE OF BIRTH:**

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NEW PATIENT INTAKE FORM

PAIN:	**WEIGHT:**	**HEIGHT:**	**AGE:**
OCCUPATION:		**Primary Care Physician:**	
Do you exercise? Yes No Describe:			
What is the main reason for your visit? (Please describe below)			
Is your condition: (Please circle) Off and On Constant Progressive Chronic			
Current problem began: (Please circle) Suddenly Gradually			
Date pain began:			

How long has this been a problem? (Please circle) **Less than 2 months 2-6 months 6-12 months Greater than 1yr**
Comments Below:

Current problem is a result of a(n): (Please circle) **Injury at Work Auto Accident Sports No Apparent Cause Other:**
Have you been treated by another provider for this condition? Yes No
If yes, please list:

What treatments have you had for this problem? (Please circle) **Nothing Chiropractic Care Acupuncture Injections Physical Therapy**		
Medications for current problem: (include Muscle Relaxants, Pain Medications, anti-inflammatory agents)		

How far can you walk?

What makes the pain or symptoms worse? (Please circle) **Exercise Sitting Standing Walking Bending Forward Bending Backward** **Pushing Pulling Night Pain Specific Activity:**
What reduces your pain? (Please circle) **Nothing Lying Down Sitting Standing Walking Medication Changing Positions**

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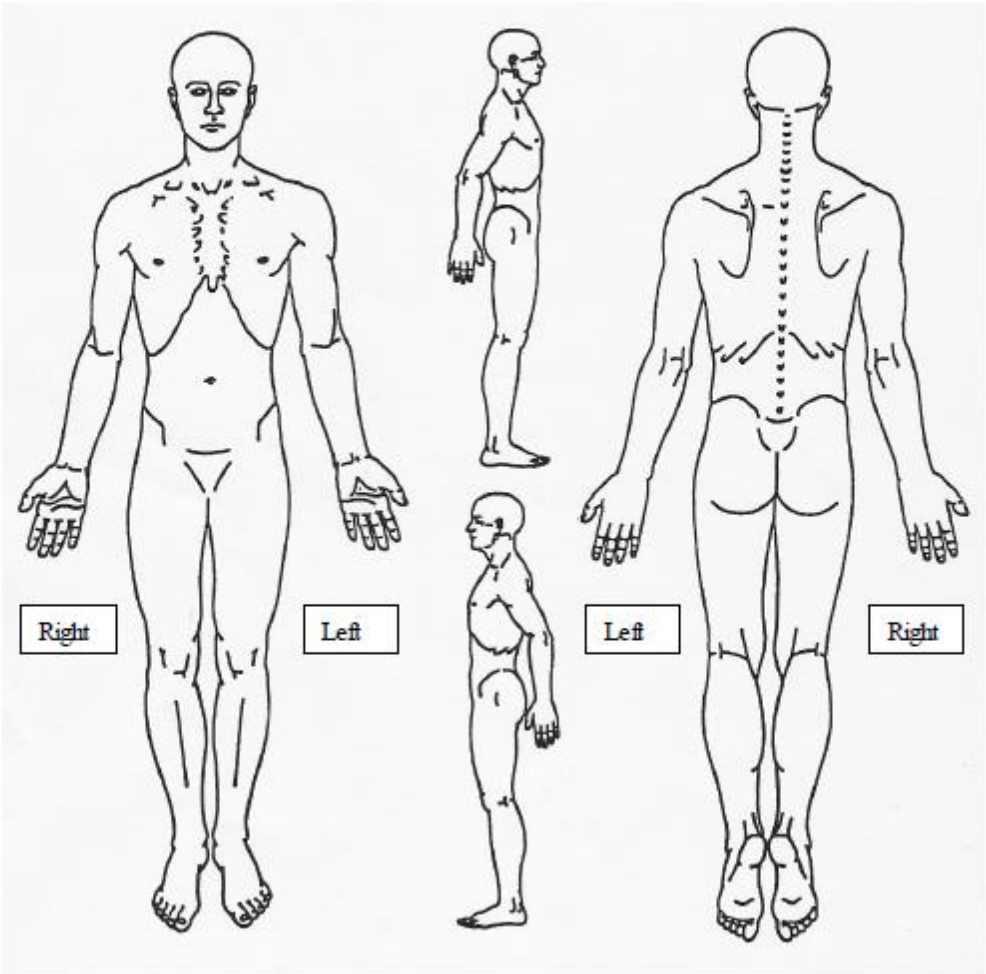
PAIN DRAWING

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

A =	Ache	B =	Burning	R =	Radiating Pain	D =	Dull Pain
N =	Numbness	S =	Stabbing	P =	Pins & Needles	O =	Other



Please indicate how you would rate your pain (LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

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Past Medical History

Surgical History

Date	Surgery	Complication

Current Medical Illnesses: Please circle all that apply for Patient and Family History

Heart Disease	Pt	Fam	Stroke	Pt	Fam	Sleep Apnea	Pt	Fam
Hypertension	Pt	Fam	Arthritis	Pt	Fam	High Cholesterol	Pt	Fam
Diabetes	Pt	Fam	Gout	Pt	Fam	Headaches	Pt	Fam
GI Upset Ulcers	Pt	Fam	Emphysema	Pt	Fam	Sickle Cell	Pt	Fam
Cancer	Pt	Fam	Skin Desease	Pt	Fam	Osteoporosis	Pt	Fam
Nerve Pain	Pt	Fam	Thyroid Disease	Pt	Fam	Liver Problems	Pt	Fam
Muscle Pain	Pt	Fam	Hepatitis	Pt	Fam	Bone-Joint Problems	Pt	Fam
Mental Disorders	Pt	Fam	Tuberculosis	Pt	Fam	Epilepsy	Pt	Fam
Bleeding Disorders	Pt	Fam	Kidney/Bladder Problems	Pt	Fam			

Medication Allergies? (Please circle) Yes No
If yes, please list:
Food Allergies? (Please circle) Yes No
If yes, please list:
Allergic to Latex? (Please circle) Yes No
If yes, please describe reaction:
Problems with Anestesia? (Please circle) Yes No
If yes, please explain:

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Medication History

Medication, Dosage and Frequency of Use: (please include OTC and Herbal products)	
1.	16.
2.	17.
3.	18.
4.	19.
5.	20.
6.	21.
7.	22.
8.	23.
9.	24.
10.	25.
11.	26.
12.	27.
13.	28.
14.	29.
15.	30.

Social History

Do you smoke?	Yes	No	If yes, Packs per day ( )	How many years? ( )	
Have you quit smoking?	Yes	No	If yes, How long ago? ( )		
Do you drink alcohol?	Yes	No	If yes, Please Circle:	Daily Weekly Monthly Yearly	
Do you use street drugs?	Yes	No	If yes, Describe type and frequency below.		

Have you had any of the following Diagnostic Studies performed?
***** If yes, bring them to the initial visit or have them sent prior to your appointment date. *****

X-Ray	No	Yes	Where	Date
Cat Scan	No	Yes	Where	Date
Myelogram	No	Yes	Where	Date
EMG Studies	No	Yes	Where	Date
Discogram	No	Yes	Where	Date
MRI	No	Yes	Where	Date
Bone Scan	No	Yes	Where	Date
Bone Density	No	Yes	Where	Date
Other	No	Yes	Where	Date

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Patient Consent Form

Patient Name (please print):	Date:

I acknowledge I have been given an opportunity to read the Privacy Practice Policy for Dr. Kraig R. Pepper, D.O. P.A. I give my consent to release personal information for the purposes of treatment, referrals, payment, or healthcare operations. I also understand I may withdraw my consent at any time in writing.

I understand my medical records may be transmitted electronically, by fax and may be received in error by a third party. In the event this should occur, I absolve the office of all liability. I give my consent to fax my records for the purposes of treatment, payment, or healthcare operation and understand I may withdraw this consent at any time in writing.

I also understand I have the right to request restrictions as to how my health information may be used or disclosed.

I also understand I have the right to revoke this consent in writing, except where the practice has already made disclosures in reliance of my prior consent.

Other person(s) permitted to receive my medical records other than in paragraph one:

□ **No restrictions – may release information to anyone if requested.**

□ **Restricions; detail below:**

_____

_____

_____

I wish to be contacted in the following manner (Please check all that apply):

Home Telephone:	Cell Phone:

□ **O.K. to leave message with detailed information**

□ **Leave message with call back number only**

Other: _____

Patient/Parent (if minor) Signature: _____ **Date:** _____

Relationship, if not patient's signature: _____

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Consents and Disclosures: I hereby voluntarily agree to diagnostic procedrues, and medical and surgical treatment, which may be administered to or performed on me under the general and special instructions of the attending provider's care and service, or the provider's designee(s).

I hereby voluntarily agree to and understand, I may be followed during my Orthopedic care at Dr. Kraig R. Pepper, D.O. P.A., by a Board Certified Orthopedic Physician Assistant, designated OPA-C, during follow up visits or post operatively at the request and designation of the attending provider.

I further understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks.No guarantees have been made to me as to the results of my treatment at Dr. Kraig R. Pepper, D.O. P.A. I further understand that Dr. Kraig R. Pepper, D.O. P.A. encourages me to ask questions and voice concerns about medical care or services and that asking questions and voicing concerns will not compromise my care. (I understand any invasive procedue will be explained, and I will be asked to sign an authorization for that treatment).

Assignment of Benefits: I hereby assign all medical and/or surgical benefits to the attending physician. A photocopy of this assignment is to be considered as valid as the original. I understand I am financially responsible for all charges whether or not paid by said insurance, I herby authorize said assigned to release all information necessary to secure payment.

BY SIGNING BELOW I CERTIFY THAT I HAVE READ THIS AGREEMENT AND/OR THAT IT HAS BEEN FULLY EXPLAINED TO ME, THAT I UNDERSTAND ITS CONTENTS AND THAT I AM THE PATIENT, OR A PERSON DULY AUTHORIZED TO EXECUTE THIS AGREEMENT AND ACCEPT ITS TERMS.

Note: A copy of this agreement may be used with the same effectiveness as an original.

Patient/Parent (if minor) Signature: _____ Date: _____

Relationship, if not patient's signature: _____

Refusal to Sign

I understand I have the right to refuse to sign this authorization, and doing so, I will assume all costs involved for my medical care. I will be responsible for full payment at each time of service. I absolve my insurance company and/or employer from and resposibility for my medical care expenses.

Patient signature: _____ Date: _____

Witness (to signature only): _____ Date: _____

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Patient Name:_____

DOB:_____

Race:_____

Language:_____

Smoker: Yes No

Weight:_____

Height:_____

Blood Pressure:_____

Pulse:_____