



General
Surgery



MEMORIAL HOSPITAL

4800 E Johnson Ave
Jonesboro, AR 72401
870-936-1000

K. Bruce Jones, M.D.
4802 E Johnson Ave
Jonesboro, Arkansas 72401
Phone: 870-936-8000
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Date: _____

Date attended seminar: _____

Circle one: Live Online

Name: _____

Address: _____ City _____ State: _____ Zip _____

Phone: _____ Email: _____

Date of Birth: _____

Social Security Number: _____

Height: _____ BMI: _____ (Office use only)

Weight _____ Ideal Weight Range: _____ Amt. Over: _____ (Office use only)

INSURANCE: (primary) _____

(secondary) _____

ID (primary) _____ group: _____

ID (secondary) _____ group: _____

Employer providing ins: (primary) _____

(secondary) _____

Effective date: _____ Deductible: _____

PCP: _____

PROCEDURE DESIRED: _____

PATIENT INFORMATION (THE PERSON SEEING THE PHYSICIAN):

DATE _____ PRIMARY CARE PHYSICIAN (PCP) _____ REFERRING PHYSICIAN _____

NAME _____
FIRST M.I. LAST SUFFIX (Jr/Sr/II etc)

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____ COUNTY _____

PHYSICAL ADDRESS _____ CITY _____ STATE _____ ZIP _____ COUNTY _____

HOME PHONE (____) _____ CELL PHONE (____) _____ SSN _____ DATE OF BIRTH _____

EMAIL ADDRESS _____

MALE FEMALE **MARITAL STATUS** SINGLE MARRIED DIVORCED WIDOWED OTHER

RACE AMERICAN INDIAN/ALASKA NATIVE ASIAN BLACK/AFRICAN AMERICAN NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER WHITE/CAUCASIAN OTHER

ETHNICITY HISPANIC/LATINO NOT HISPANIC/NOT LATINO OTHER **LANGUAGE** ENGLISH SPANISH OTHER _____

EMPLOYER _____ Full Time Part Time WORK PHONE (____) _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE NAME _____ SPOUSE EMPLOYER _____

PHARMACY _____ PHARMACY PHONE _____

Is the patient a student? Y / N Fulltime? Y / N

Which method of communication is preferred? No contact Mail Phone Email MyChart

How did you hear about NEA Baptist Clinic? Billboard Employee Friend/Family Newspaper Physician Referred Radio TV Website Yellow Pages Other

EMERGENCY CONTACT

NAME _____
FIRST M.I. LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (____) _____ CELL PHONE (____) _____ RELATIONSHIP TO PATIENT _____

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR THE BILL. IF OVER 18 SHOULD BE PATIENT):

GUARANTOR NAME _____ DOB _____
FIRST M.I. LAST

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____ COUNTY _____
(STREET, ROUTE)

HOME PHONE (____) _____ CELL PHONE (____) _____ SSN _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ Full Time Part Time ADDRESS _____ PHONE _____

IS THIS WORKERS COMP RELATED? Y / N **Date of Injury** _____

PRIMARY INSURED (THE PERSON WHO CARRIES THE INSURANCE):

SUBSCRIBER _____
FIRST M.I. LAST

PHYSICAL ADDRESS _____
(STREET, ROUTE)

CITY _____ STATE _____ ZIP _____

PHONE (____) _____

SSN _____ DATE OF BIRTH _____

RELATIONSHIP TO PATIENT Spouse Parent Other _____

EMPLOYER _____

PHONE (____) _____

INSURANCE INFORMATION

PRIMARY INSURANCE (MUST HAVE COPY OF CARD):

INSURANCE NAME _____

GROUP# _____ POLICY/ ID# _____

EFFECTIVE DATE OF INSURANCE: _____

DOES PRIMARY INSURANCE REQUIRE A REFERRAL? Y / N

SECONDARY INSURED

SUBSCRIBER _____
FIRST M.I. LAST

PHYSICAL ADDRESS _____
(STREET, ROUTE)

CITY _____ STATE _____ ZIP _____

PHONE (____) _____

SSN _____ DATE OF BIRTH _____

RELATIONSHIP TO PATIENT Spouse Parent Other _____

EMPLOYER _____

PHONE (____) _____

INSURANCE INFORMATION

SECONDARY INSURANCE (MUST HAVE COPY OF CARD):

INSURANCE NAME _____

GROUP# _____ POLICY/ ID# _____

EFFECTIVE DATE OF INSURANCE: _____

DOES SECONDARY INSURANCE REQUIRE A REFERRAL? Y / N

Signature _____ Date _____

OFFICE USE ONLY - SCAN DOCUMENT UNDER Amb_Registration Forms

HEALTH HISTORY SHEET

THE FOLLOWING INFORMATION IS VERY IMPORTANT TO YOUR HEALTH. PLEASE TAKE TIME TO FULLY AND COMPLETELY FILL OUT THIS IMPORTANT INFORMATION. WE ARE COUNTING ON YOU.

NAME		TODAY'S DATE	
AGE		BIRTHDATE	
DESCRIBE WHY YOU ARE HERE TODAY			
HAVE YOU BEEN TO ER OR DOCTOR?			
HAVE YOU HAD X-RAYS OR SCANS FOR THIS PROBLEM?		WHEN AND WHERE?	

SIGNS AND SYMPTOMS: (CHECK ALL THAT APPLY)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Inflammation of the veins (phlebitis) | <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Easy bruising |
| <input type="checkbox"/> Overly tired | <input type="checkbox"/> Skin ulcers of the legs | <input type="checkbox"/> Bloody stool | <input type="checkbox"/> Muscle wasting |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Coughing excessive phlegm | <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Loss of strength |
| <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Bleeding on urination | <input type="checkbox"/> Recent use of steroids or other drugs that affect immunity |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Shortness of breath (can't go up one flight of stairs without stopping) | <input type="checkbox"/> Difficulty urination | <input type="checkbox"/> Frequent infections |
| <input type="checkbox"/> Bleeding from gums | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Suicide attempts |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Black stool | <input type="checkbox"/> Change in size or color of moles | <input type="checkbox"/> Abnormal vaginal bleeding |
| <input type="checkbox"/> Chest pain | | <input type="checkbox"/> Seizures or passing out | |
| <input type="checkbox"/> Fainting | | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Passing out | | <input type="checkbox"/> Bleeding easy | |
| <input type="checkbox"/> Feel heart beating | | | |

MEDICAL PROBLEMS: (CHECK ALL THAT APPLY)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Abnormal Echocardiogram | <input type="checkbox"/> Diabetes, insulin dependent | <input type="checkbox"/> Blood clotting disorder (coagulopathy) | <input type="checkbox"/> Hypertension (high blood pressure) |
| <input type="checkbox"/> Heart disease (coronary disease or heart failure) | <input type="checkbox"/> Diabetes, not insulin dependent | <input type="checkbox"/> Blood clot in extremities (venous thrombosis) | <input type="checkbox"/> Elevated cholesterol |
| <input type="checkbox"/> Lung disease (emphysema, asthma, COPD) | <input type="checkbox"/> Seizure disorder, epilepsy | <input type="checkbox"/> Blood clot in lung (pulmonary embolus) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Renal failure | <input type="checkbox"/> Psychiatric illness | <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid disease |
| | | | <input type="checkbox"/> Prostate disease |
| | | | <input type="checkbox"/> Reflux, GERD |
| | | | <input type="checkbox"/> Ulcer disease |

HEIGHT: _____ WEIGHT: _____

INFECTIOUS DISEASES:

<input type="checkbox"/> Hepatitis
<input type="checkbox"/> AIDS / HIV
<input type="checkbox"/> History of blood transfusion

WOMEN ONLY:		
Date of last menstrual period:	Are you Pregnant?	How far along?
Date of late Pap smear	Number of children	
Date of last mammogram and where	Number of pregnancies?	

PLEASE COMPLETE BACK OF FORM

MEDICATIONS: List medications you are CURRENTLY taking including over-the-counter nonprescription drugs		

ALLERGIES: Medications and substances (i.e. latex)

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HOSPITALIZATIONS AND OPERATIONS: Include C-sections, and endoscopies (i.e. colonoscopy and EGD)

FAMILY HISTORY: (Include problems with anesthesia, cancer and kind if known, and colon polyps) (If deceased: age at death and cause of death)

Father
Mother
Sister(s)
Brother(s)
Other (grandparents, aunts and uncles)

SOCIAL HISTORY: (how much use, and if quit when)

<input type="checkbox"/> Tobacco	How much?	How long?	Quit? If so when?
<input type="checkbox"/> Drugs	Type?	How much?	How long? Quit? If so when?
<input type="checkbox"/> Alcohol	How much?	How long?	Quit? If so when?
OCCUPATIONAL CONCERNS:			
Heavy lifting			
Your occupation			
Your education			

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her employ responsible for any errors or omission that I may have made in the completion of this form.

Date

Signature

BARIATRIC MEDICAL ISSUES

NAME: _____ Date _____
 Date of birth _____

PRESENT WEIGHT: _____
 HIGHEST WEIGHT: _____
 WEIGHT IN LATE TEEN YEARS: _____

FAMILY HISTORY OF OBESITY:

Father: []Yes []No
 Mother: []Yes []No
 Brothers: []Yes []No
 Sisters: []Yes []No

PERSONAL MEDICAL PROBLEMS RELATED TO OBESITY:

	YES	NO	Comment:
Diabetes			
High Blood Pressure			
Heart Failure			
Shortness of breath			
Nighttime shortness of breath (sleep apnea)			
Reflux, indigestion, or heart burn			
Gallbladder disease			
High cholesterol or triglycerides			
Leg swelling			
Varicose veins			
Blood clots			
Sores on abdomen, skin, or in skin folds			
Irregular menstrual periods			
Depression and/or Anxiety			
Urinary incontinence			
Degenerative joint disease			
Arthritis or disease of the spine			
Headaches			
Other:			

DIETARY HABITS

Name: _____ Date _____

Date of birth _____

How many meals per day do you eat? _____

Do you eat large meals? _____

Do you eat sweets? If so, how many times per day? _____

Do you eat snacks? If so, how many times per day? Be sure to include small snacks such as a cracker, etc. _____

Do you drink sugar sweetened drinks such as a sweet tea or soft drinks? If so, how many? _____

Do you eat fatty foods? _____ How many servings per day? _____

Present Medications

DRUG

DOSAGE

FREQUENCY

ALLERGIES: _____

Have you ever had your thyroid hormone level checked? _____

WEIGHT LOSS ATTEMPTS AND DIETS

NAME: _____

DATE: _____

Date of birth _____

PLEASE COMPLETE THE FOLLOWING (be specific by listing each diet by name):

Type of Weight loss program	Tried (list # of times)	Length of trial	Total weight loss	Approximate # of years ago
Weight Watchers				
Doctor supervised diets				
Diet Centers				
Prescription diet pills				
Behavior modification				
Psychotherapy (group or individual)				
Self-Supervised Diets (List all other attempted diets)				
Counting fat grams				
Protein sparing diet (Nutrisystem, Optifast, Medifast, Slim fast)				



HIPAA PRIVACY NOTICE
ACKNOWLEDGMENT

Patient Name: _____
First Middle Initial Last

DOB: _____ MRN: _____ SSN: _____

The signature below acknowledges a copy of this Notice was RECEIVED (not necessarily read).

Date Patient/Legal Representative Signature

State Capacity, if Legal Representative

For internal use only

Lack of Patient Acknowledgment:

Date Reason Staff Signature

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

With whom may we share information about your health? Please list below.

Note: In order for NEA to disclose your Private Health Information, the representative listed must be able to provide (2) two of the (3) identifiers listed below:

1. Last 4 digits patient's social security number

2. Patient's date of birth

3. Patient's zip code

Table with 5 columns: Name, Relationship to You, Telephone Number, May Discuss Diagnosis/Treatment, May Discuss Billing Info. Includes checkboxes for Yes/No.

Do you have a legal document that states who will make decisions if you are unable? Yes No

If yes, Name Relationship to Patient

Check one: Healthcare Proxy/Agent General Power of Attorney Healthcare Power of Attorney

If you would like information about appointing a healthcare proxy/agent, please let us know.

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to discuss and use the patient's healthcare information.

Patient/Legal Representative Signature: Date:

If legal representative, explain the capacity:

OFFICE USE ONLY - SCAN DOCUMENT UNDER HIPAA NOTICE OF PRIVACY

Date _____ DOB _____ MRN _____

Patient Name _____
First Middle Initial Last

Communications Regarding My Account

Initial Here _____ I agree that the facility, NEA Baptist Clinic, or any other collection or servicing agency or agencies retained by the facility or my physicians (together referred to hereafter as “collectors”) to collect any money that I owe to the facility, may contact me by telephone or text message at any number given by me or that is or becomes associated with me or my account from sources other than me, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

General Consent to Treatment and Test

Initial Here _____ I am voluntarily seeking medical treatment. I consent to examination by the physician, nurse practitioner, nurse and other health care professionals at this clinic. I also consent to any medical procedures, x-ray, laboratory tests or other health care services ordered by the health care team. I understand that I may refuse specific treatments or procedures by informing the health care team. I understand that a clinical summary of today’s visit is available upon request within 72 hours.

Release of Information

Initial Here _____ I authorize NEA Baptist Clinic to release any medical information necessary to process payment of my claim.

Assignment of Insurance Benefits and Acceptance of Financial Responsibility

Initial Here _____ I authorize payment directly to NEA Baptist Clinic for their fees. I understand and agree that if any part of my account is not paid by insurance, I am financially responsible. I also understand that I may qualify for financial assistance for services provided by NEA Baptist Clinic and that I may request an application to apply for financial assistance. I further understand that the determination of whether I qualify for financial assistance is dependent upon my timely submittal of appropriate financial documentation and my failure to provide any such documentation could affect my ability to qualify for financial assistance.

SIGNATURE OF PATIENT/PARENT/GUARDIAN/PERSON AUTHORIZED TO SIGN FOR PATIENT

Date _____