NEA BAPTIST CLINIC | General Surgery

NEA BAPTIST 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
Fax: 870-934-3629

Date:_____ Date attended seminar:_____

Circle one: Live Online

*Name:_____

*Address:_____City_____State:_____Zip_____

*Phone:_____Email:_____

____I do not use e-mail, please mail my requirements to me.

*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)_____

Private Pay? (circle one): Yes No

*PCP:_____

PROCEDURE DESIRED:_____

**Indicates required field*

NEA BAPTIST CLINIC

PATIENT INFORMATION

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

NEA BAPTIST CLINIC | General Surgery

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)

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

MEDICAL PROBLEMS: (CHECK ALL THAT APPLY)

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

HEIGHT:_____ WEIGHT:_____

INFECTIOUS DISEASES:

- ☐ Hepatitis
- ☐ AIDS / HIV
- ☐ 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)

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)				
☐ Tobacco	How much?	How long?	Quit? If so when?	
☐ Drugs	Type?	How much?	How long?	Quit? If so when?
☐ 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**

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?_____

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			
Thyroid Disease			
Headaches			
Other:			

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, carbs, calories, etc.				
Protein sparing diet (Nutrisystem, Optifast, Medifast, Slim fast)				

Please do not leave this form blank

NEA BAPTIST CLINIC

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**

Name	Relationship to You	Telephone Number	May Discuss Diagnosis/Treatment	May Discuss Billing Info
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No	☐ 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

NEA BAPTIST CLINIC

Authorizations & Consents

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.

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

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