Kagan, Jugan, & Associates

Patient Biographical Form

PLEASE PRINT

Date_______________

Patient's Name: (Last)_____________________________________ (First)____________________________ (MI) __________

Social Security #: ____________________________ DOB: ______________ Age: _______

Sex: (please circle) **M** **F** Marital Status: (Please Circle) M S D W

Address: ____

City: ____ State: __________________ Zip: _______________

Northern Address (#2): ____

City: ____ State: __________________ Zip: _______________

Home Phone#: _______________________________________ Cell Phone #: ______________________________________

Emergency Contact:______________________________Emergency Phone#:_______________________________________

Employer:_______________________________________Employer Phone#:____

Occupation:____

Primary Care Physician: ______________________________________ Phone #: ( )_____________________________

Referral Source: ____ HIPPA Form Received: _______________________

PAST MEDICAL HISTORY

Medical Problems (List All): ____

____

Surgeries (List type of surgery and physician performing surgery): ____

____

Allergies (List All): ____

____

Drug Allergies: ____ Known Side Effects: _________________________________

Food Allergies: _______________________________________ Known Side Effects: ________________________________

Medications (List All): ____

Date of Accident/Injury: ___________________ Where did the injury occur? _______________________________________

How did the injury occur? ___________________________________ If no injury, when did the pain start? _______________

PAST FAMILY MEDICAL HISTORY

	Heart Trouble	High Blood Pressure	Arthritis	Diabetes	Back Problems	Neck Problems	Other
Father's Name:							
Mother's Name:							
Sister's Name:							
Brother's Name:							
Other Name:							
Other Name:							

SOCIAL HISTORY

Hand Dominance (Please Circle): **Right or Left**

Have you ever smoked? _________ If yes, (please circle) CIGARETTES, PIPE, CIGARS and how many per day? ________

How long ago did you quit? ____________

Do you consume Alcohol (Please Circle): **Yes No** If yes, how much per week:___________________________

Who do you live with? ________Self ________Family ________Friends ________ Other (explain)_____________________

Date of Accident/Injury: __________________ Where did the injury occur? _______________________________________

How did the injury occur? __________________________________ If no injury, when did the pain start? ______________

When did you last work? ____

PLEASE INDICATE ALL THE AREAS OF YOUR BODY IN WHICH YOU HAVE PAIN

Location	Right	Left	Sharp	Dull	Other	Frequency occas/interm/contsant	Intensity *see below
Shoulder							
Elbow							
Wrist							
Hand							
Knee							
Hip							
Ankle							
Foot							
Neck							
Back							
Upper Back							
Lower Back							

*INTENSITY OF PAIN: Indicate your pain intensity using the following guide: Slight 1 – 4 Moderate 5 – 7 Severe 8 – 10

WHICH OF THE FOLLOWING MAKES THE PAIN WORSE?

Sitting ______ Standing ______ Walking ______ Bending ______ Lifting (pounds) ______ Other ______

WHICH OF THE FOLLOWING MAKES THE PAIN BETTER?

Sitting ______ Standing ______ Walking ______ Bending ______ Lifting (pounds) ______ Other ______

Are you having any bowel or bladder trouble? ___________________ Any numbness or tingling? ___________________

Have you had any trauma's or work related injuries? ________ If yes, explain: ________________________________

Do you use a cane or a walker on a regular basis?
____

TREATMENT FOR CURRENT INJURY

Have you had any of the following due to this injury:

______Emergency Room Visits - Name of Hospital ____

______Hospitalizations - Name of Hospital _____________________________________ How long? _______________

Have you been seen by any other doctors for this injury? ______ Name:____

What treatment did they give you? ____

Did you receive any of the following diagnostic studies?

____Xrays - Body Part _______________________ Facility: ____

____MRI – Body Part _______________________Facility: ____

____CT Scan/Bone Scan – Body Part _____________________ Facility: ___________________________________

____Blood Work: **YES or NO**

____EMG/NCV Studies/Myelograms – Where? ____

Was any surgery performed? _________ If yes, list type of surgery, Doctor's Name, and the date of procedure: ________

____

INSURANCE INFORMATION

Do you have medicare? ________ If yes, please skip to secondary insurance.

Name of Primary Insurance: __________________________________ Phone #: (   )______________________

Billing Address: ____________________________________City: ______________________ State/Zip: ___________

Insured name: (Last)______________________________ (First)______________________________ (MI)__________

Insured SS# (If not the patient): ____________________ Insured Date of Birth: ___________________ Insured Sex: _____

Relationship to patient: __________________________________ Group #: _________________________________

Name of Secondary Insurance: _________________________________ Phone #: (   ) ______________________

Billing Address: ____________________________________ City: _____________________State/Zip: ___________

Insured Name: (Last) ______________________________ (First)_____________________________(MI)__________

Insured SS# (If not the patient): ____________________ Insured Date of Birth: ___________________Insured Sex: _____

Relationship to patient:____________________________________ Group #: _________________________________

Attorney's Name: ____ Attorney Phone: (   ) _______________________

Address: ____City: _______________________State/Zip: ___________

IF UNDER 18, PLEASE PRINT NAME & ADDRESS OF RESPONSIBLE PARTY:

NAME:____

ADDRESS:____

I hereby authorize treatment by **KAGAN, JUGAN, & ASSOCIATES, MD, PA** as deemed reasonable and necessary by him at the time of my visit.

____________________________ ____

Date Signature of Patient/Guardian

I, ____________________________________, hereby assign all medical and/or surgical benefits, to which I am entitled to KAGAN, JUGAN, & ASSOCIATES, MD, PA. A copy/fax of this assignment is as valid as the original.

____________________________ ____

Date Signature of Patient/Guardian