DEBORAH S. ST.CLAIR M.D.
ORTHOPEDIC SURGERY

1100 Bishop St.
Union City, TN 38261
731-885-0111

Fax 731-599-4226

1718 Parr Ave Suite D
Dyersburg, TN 38024
731-288-2446

Patient Name:_____DOB:_____Telephone (_____)_____

Address:_____City_____State_____Zip_____

Marital Status: Single Married Divorced Widowed Sex:_____ Social Security #_____

Employer Information

Company:_____Position:_____

Address:_____City_____State____Zip_____Phone(___)_____

Spouse Information

Name:_____DOB:_____SS#:_____

Employer:_____

Address:_____City:_____State:____Zip:_____Phone(_____)_____

Spouse Ins Co:_____ Policy#:_____Group #:_____

Address:_____Phone:(_____)_____

In Case Of Emergency Contact:_____Relationship:_____Phone:(_____)_____

GUARANTOR NAME IF NOT PATIENT:_____

Referred By:

Name:_____Address:_____Phone:(____)_____

INSURANCE: (PLEASE PRESENT CURRENT INSURANCE/MEDICAL CARD TO RECEPTIONIST)

Primary Insurance Company

Name:_____ Policy #:_____Group #:_____

Address:_____Phone:(_____)_____

Insured's Name:_____ Relationship To Pt:_____

Comments/Referral#:_____

Secondary Insurance Company

Name:_____ _Policy #:_____Group #:_____

Address:_____Phone:(_____)_____

Insured's Name:_____ Relationship To Pt:_____

Comments/Referral#:_____

Is this visit due to an employment-related or auto accident? Yes No

Date Of Injury:_____ If yes, Nature and Location of Accident_____

PERMISSION FOR TREATMENT: Permission is hereby granted to DEBORAH S. StClair M.D. to render such medical treatment as is deemed necessary.

RELEASE OF INFORMATION: To the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement, DEBORAH S. ST.CLAIR M.D. may disclose portions of the patient's medical record and account to any person or corporation which is or maybe liable for all or any portion of the patient's charges including but not limited to insurance companies, health care service plans or workers compensation carriers. The patient's medical record may also be released to the referring physician to ensure continuity of medical care.

FINANCIAL AGREEMENT: In consideration of the services rendered to the patient, the undersigned agrees to accept full financial responsibility for the patient's account in accordance with the regular rates and terms of the facility. Should the account be referred for collections, the undersigned shall pay reasonable attorney's fees and collection benefits. I shall pay any and all copayments or deductibles due at time of service. I agree that I will pay a monthly late fee of 1.5% of any uncollected balance after 30 days of the charges being rendered. I am responsible for the charges if I do not have an approved referral.

ASSIGNMENT OF INSURANCE BENEFITS: I request my insurance carrier to pay Deborah S. St.Clair M.D. all benefits due me related to my pending claim for medical and surgical services.

MEDICARE B AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers or to the billing agent of this physician, any request payment of medical insurance benefits to the party who accepts assignment.

I have read and approved all of the above except for those items I have personally lined through and initialed.

Signature of Insured/Guardian/Patient_____Date_____

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Patient Name:_____ Date:_____

1. Please describe your medical problem:_____
   How did it start: Accident Sudden Gradual Side of injury: Right Left
   Date it began: _____ Where did it happen?:_____
   Who have you seen for your illness: _____
   Name of Family Doctor: _____

2. Please list and describe your past medical illness:_____

   _____

Have ***YOU*** had any of these? Please Circle:

Diabetes	Heart Condition	Acid Reflux	ADD
(Oral Medication or Insulin)	Borderline Diabetes	Hypoglycemia	Chronic Back Pain
High Blood Pressure	Heart Attack	Any Cancer (list)_____	AIDS
Blood Vessel Blockage	Seizures/Epilepsy	Stroke/Paralysis	Depression
Phlebitis/Blood Clots	Hepatitis	Poor Vision	Weakness
Migraine	Blood Transfusion	Poor Hearing	Asthma
Other Headache	Stomach Ulcer	Vertigo/Dizziness	Other Arthritis
Gout	Rheumatoid Arthritis	Other Fracture	Fibromyalgia
COPD	Emphysema	Anxiety	Thyroid

3. Have you had any operations? Please List:

   _____ _____ _____

   _____ _____ _____

   _____ _____ _____

4. Please list any medications you are taking:

   _____ _____ _____

   _____ _____ _____

   _____ _____ _____

   _____ _____ _____

   _____ _____ _____

5. Please list medication allergies:

   _____ _____ _____

6. Family History:

   Father's age_____ Illness_____ Cause of death_____

   Mother's Age_____ Illness_____ Cause of death_____

   Brothers_____

   Sisters_____

7. Has anybody in your immediate ***family*** ever had? Please Circle:

High Blood Pressure	Stroke	COPD	Chronic Pain
Heart Disease	Mental Illness	Emphysema	
Cancer Where_____	Epilepsy	Asthma	
Diabetes (high or low blood sugar)	Migraine	Fibromyalgia	

8. Weight history:

   Present weight _____ Usual Weight_____

   Any major changes in weight? How much_____

9. Habit History:

   A. Smoking:

      1.Cigarettes packs daily _____ How long_____ Date Stated_____ Date Stopped_____
      2. Cigars # per day_____ How long_____ Date Stated_____ Date Stopped_____
      3. Pipe # per day_____ How long_____ Date Stated_____ Date Stopped_____

   B. Alcohol: Never____ Occasional_____ Moderate_____ Heavy_____
   C. Any type of Drug or Alcohol Treatment? Y N Name:_____ Dates:_____

   D. Television and computer:

      Hours spent watching T.V._____ On the computer_____

10. Hobbies:

    List your hobbies: _____

    _____