

Date: _____

Dr. EJ Jones

Patient Information

Name _____ Phone: Home _____ Cell _____

Address _____ City _____ State _____

Zip _____

Birthday _____ Social Security # _____ Age _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employer _____ Phone: Work _____

Emergency Contact _____ Phone # _____

Primary Care Doctor _____ Referring Doctor _____

Primary Insurance

Insurance Company _____ Cardholders Name _____

Birthday _____ Social Security # _____

Phone: Home _____ Work _____

Address (if different from patients) _____ City _____

State _____ Zip _____

Id# _____ Group# _____

Secondary Insurance

Insurance Company _____ Cardholders Name _____

Birthday _____ Social Security # _____

Phone: Home _____ Work _____

Address (if different from patients) _____ City _____

State _____ Zip _____

Id# _____ Group# _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr EJ Jones all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of all benefits. I authorize the use of this signature on all insurance submissions.

Signature _____ Date: _____

E.J. Jones, M.D.

Receipt of Notice of Privacy Practices

Written Acknowledgment

I, _____ have received a copy of
E.J. Jones Notice of Privacy Practices.

Signature _____ Date _____

Please Read!!!!

If you are here today for your annual exam your insurance may pay 100 % on a wellness exam. There are many exceptions to your wellness benefits, depending on your insurance company and plan. If you are here and also have a problem for that appointment your insurance could pay the entire visit or apply it to your deductible or co-insurance.

Example 1: You are here today and have your wellness exam and Pap smear. You also have hot flashes and would like lab done. I will bill your pap and visit under your wellness plan. Your lab can not be billed under your wellness and will have to be filed with a diagnosis. Your insurance will pay at your wellness benefit plan then apply your lab to your deductible or co-insurance, depending on your insurance plan.

Example 2: You are here today and only get your pap and wellness visit done. When we send your pap to the lab for testing and it comes back abnormal and Dr. Jones may need additional test ran on the pap to decide the correct level of care. Then your insurance may not consider this as wellness for the additional test and apply a part of the cost to your co-insurance but still pay for the wellness part of it.

Please let me know if you have any questions. Thanks, Carey

I have read and understand that I will responsible for any part that my insurance may apply to patient responsibility.

Signature: _____ Date: _____

COMMUNICATIONS REGARDING MY ACCOUNT

I agree that the facility, E.J. Jones, M.D., or any other collection or servicing agency or agencies retained by the facility (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 otherwise associated with my account, 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.

Signature of Patient/Guarantor/Consumer



E.J. JONES, M.D.

DIPLOMATE, AMERICAN BOARD OF
OBSTETRICS AND GYNECOLOGY
FELLOW, AMERICAN COLLEGE OF
OBSTETRICS AND GYNECOLOGY

255 VIRGINIA DRIVE
BATESVILLE, AR 72501
(870) 793-4300

AUTHORIZATION TO RECEIVE MEDICAL TREATMENT

This is to certify that I, the undersigned, hereby consent to and authorize the administration and performance of all diagnostic procedures and/or such medical, surgical treatments which in the judgment of Dr. E.J. Jones or his authorized agent may be considered necessary or advisable. No guarantee has been made as a result of treatments or examinations.

Patient/Authorized Legal Representative

Date

Dr. EJ Jones

FOR OFFICE USE ONLY
☐ NEW PATIENT
☐ ESTABLISHED PATIENT
☐ CONSULTATION
☐ REPORT SENT: / /

PATIENT INTAKE HISTORY

PATIENT NAME:		BIRTH DATE: / /	ID NO.:	DATE: / /
ADDRESS:				
CITY:		STATE/ZIP:		
HOME TELEPHONE: ()		WORK TELEPHONE: ()		
EMPLOYER:		INSURANCE:		
NAME YOU WOULD LIKE US TO USE:				
NAME OF SPOUSE/PARTNER:		EMERGENCY CONTACT:		
		RELATIONSHIP:		
		HOME TELEPHONE: ()		WORK TELEPHONE: ()
REFERRED BY:				
WHY HAVE YOU COME TO THE OFFICE TODAY?				
IF YOU ARE HERE FOR AN ANNUAL EXAMINATION IS THIS A <input type="checkbox"/> PRIMARY CARE VISIT OR <input type="checkbox"/> GYNECOLOGY ONLY				
IS THIS A NEW PROBLEM?				
PLEASE DESCRIBE YOUR PROBLEM, INCLUDING WHERE IT IS, HOW SEVERE IT IS, AND HOW LONG IT'S LASTED.				

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

GYNECOLOGIC HISTORY

	PHYSICIAN'S NOTES
LAST NORMAL MENSTRUAL PERIOD (FIRST DAY): / /	
AGE PERIODS BEGAN:	
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING):	
NUMBER OF DAYS BETWEEN PERIODS:	
ANY RECENT CHANGES IN PERIODS?	
ARE YOU CURRENTLY SEXUALLY ACTIVE?	
HAVE YOU EVER HAD SEX?	
NUMBER OF SEXUAL PARTNERS (LIFETIME):	
SEXUAL PARTNERS ARE <input type="checkbox"/> MEN <input type="checkbox"/> WOMEN <input type="checkbox"/> BOTH	
PRESENT METHOD OF BIRTH CONTROL:	
HAVE YOU EVER USED AN INTRAUTERINE DEVICE (IUD) OR BIRTH CONTROL PILLS?	
IF YES, FOR HOW LONG?	
WHEN WAS YOUR LAST PAP TEST?	
WHAT WAS THE RESULT?	
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?	
DO YOU DO REGULAR BREAST SELF-EXAMINATIONS?	

E. Jones MD.

PATIENT

NTAKE HISTORY (Continued)

BIRTH DATE: / /

ID NO.:

DATE: / /

OBSTETRIC HISTORY

		NUMBER			NUMBER			NUMBER
PREGNANCIES			ABORTIONS			MISCARRIAGES		
PREMATURE BIRTHS (<37 WEEKS)			LIVE BIRTHS			LIVING CHILDREN		
NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)	COMPLICATIONS?		
1.								
2.								
3.								
4.								
PHYSICIAN'S NOTES ON OBSTETRIC HISTORY:								

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

FAMILY HISTORY

MOTHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED—CAUSE:		AGE:	FATHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED—CAUSE:		AGE:
SIBLINGS: NUMBER LIVING:		NUMBER DECEASED:	CAUSE(S)/AGE(S):		
CHILDREN: NUMBER LIVING:		NUMBER DECEASED:	CAUSE(S)/AGE(S):		
ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET	PHYSICIAN'S NOTES		
DIABETES	<input type="checkbox"/>				
STROKE	<input type="checkbox"/>				
HEART DISEASE	<input type="checkbox"/>				
BLOOD CLOTS IN LUNGS OR LEGS	<input type="checkbox"/>				
HIGH BLOOD PRESSURE	<input type="checkbox"/>				
HIGH CHOLESTEROL	<input type="checkbox"/>				
OSTEOPOROSIS (WEAK BONES)	<input type="checkbox"/>				
HEPATITIS	<input type="checkbox"/>				
HIV/AIDS	<input type="checkbox"/>				
TUBERCULOSIS	<input type="checkbox"/>				
BIRTH DEFECTS	<input type="checkbox"/>				
DRINKING OR DRUG PROBLEMS	<input type="checkbox"/>				
BREAST CANCER	<input type="checkbox"/>				
COLON CANCER	<input type="checkbox"/>				
OVARIAN CANCER	<input type="checkbox"/>				
UTERINE CANCER	<input type="checkbox"/>				
MENTAL ILLNESS/DEPRESSION	<input type="checkbox"/>				
ALZHEIMER'S DISEASE	<input type="checkbox"/>				
OTHER	<input type="checkbox"/>				

Dr. EJ Jones

TAKE HISTORY (Continued)

BIRTH DATE: / /

ID NO.:

DATE: / /

SOCIAL HISTORY

	YES	NO	PHYSICIAN'S NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:	<input type="checkbox"/>	<input type="checkbox"/>	
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK:	<input type="checkbox"/>	<input type="checkbox"/>	
RECREATIONAL DRUG USE	<input type="checkbox"/>	<input type="checkbox"/>	
SEAT BELT USE	<input type="checkbox"/>	<input type="checkbox"/>	
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?	<input type="checkbox"/>	<input type="checkbox"/>	
DAIRY PRODUCT INTAKE/CALCIUM SUPPLEMENTS: QUANTITY	<input type="checkbox"/>	<input type="checkbox"/>	
HEALTH HAZARDS AT HOME OR WORK?	<input type="checkbox"/>	<input type="checkbox"/>	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?	<input type="checkbox"/>	<input type="checkbox"/>	

PERSONAL PROFILE

SEXUAL ORIENTATION: <input type="checkbox"/> HETEROSEXUAL <input type="checkbox"/> HOMOSEXUAL <input type="checkbox"/> BISEXUAL
MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> LIVING WITH PARTNER <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
NUMBER OF LIVING CHILDREN:
NUMBER OF PEOPLE IN HOUSEHOLD:
SCHOOL COMPLETED: <input type="checkbox"/> HIGH SCHOOL <input type="checkbox"/> SOME COLLEGE/AA DEGREE <input type="checkbox"/> COLLEGE <input type="checkbox"/> GRADUATE DEGREE <input type="checkbox"/> OTHER
CURRENT OR MOST RECENT JOB:
TRAVEL OUTSIDE THE U.S.? LOCATION:

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
ASTHMA				
PNEUMONIA/LUNG DISEASE				
KIDNEY INFECTIONS/STONES				
TUBERCULOSIS				
SEXUALLY TRANSMITTED DISEASE				
HIV/AIDS				
HEART ATTACK/PROBLEMS				
DIABETES				
HIGH BLOOD PRESSURE				
STROKE				
RHEUMATIC FEVER				
BLOOD CLOTS IN LUNGS OR LEGS				
EATING DISORDERS				
COLLAGEN VASCULAR DISEASE (LUPUS)				
CHICKENPOX				
CANCER				
REFLUX/HiATAL HERNIA/ULCERS				
DEPRESSION/ANXIETY				
ANEMIA				
BLOOD TRANSFUSIONS				
SEIZURES/CONVULSIONS/EPILEPSY				
BOWEL PROBLEMS				
GLAUCOMA				
CATARACTS				
ARTHRITIS/JOINT PAIN/BACK PROBLEMS				
BROKEN BONES				
HEPATITIS/YELLOW JAUNDICE/LIVER DISEASE				
THYROID DISEASE				

Dr. EJ Jones

AKE HISTORY (Continued)

BIRTH DATE:

/ /

ID NO.:

DATE: / /

PERSONAL PAST HISTORY OF ILLNESSES (Continued)

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
GALLBLADDER DISEASE				
HEADACHES				
OTHER				

OPERATIONS/HOSPITALIZATIONS

REASON	DATE	HOSPITAL

INJURIES/ILLNESSES

TYPE	DATE	TYPE	DATE

IMMUNIZATIONS/TEST

	DATE		DATE
TETANUS-DIPHTHERIA BOOSTER		INFLUENZA VACCINE (FLU SHOT)	
HEPATITIS A VACCINE		HEPATITIS B VACCINE	
VARICELLA VACCINE		PNEUMOCOCCAL VACCINE	
MEASLES-MUMPS-RUBELLA (MMR) VACCINE		TUBERCULOSIS (TB) SKIN TEST: RESULT:	

PHYSICIAN'S NOTES:**REVIEW OF SYSTEMS**

Please check (x) if any of the following symptoms apply to you now or since adulthood

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
1. CONSTITUTIONAL				
WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
WEIGHT GAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FEVER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FATIGUE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHANGE IN HEIGHT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Dr. E. Jones

KE HISTORY (Continued)

BIRTH DATE: / /

ID NO.:

DATE: / /

IF SYSTEMS (Continued)

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
2. EYES				
DOUBLE VISION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SPOTS BEFORE EYES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
VISION CHANGES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
GLASSES/CONTACTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. EAR, NOSE, AND THROAT				
EARACHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
RINGING IN EARS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HEARING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SINUS PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SORE THROAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MOUTH SORES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DENTAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. CARDIOVASCULAR				
PAINFUL BREATHING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHEST PAIN OR PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DIFFICULTY BREATHING ON EXERTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SWELLING OF LEGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
RAPID OR IRREGULAR HEARTBEAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. RESPIRATORY				
WHEEZING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SPITTING UP BLOOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHRONIC COUGH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. GASTROINTESTINAL				
FREQUENT DIARRHEA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BLOODY STOOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NAUSEA/VOMITING/INDIGESTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CONSTIPATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INVOLUNTARY LOSS OF GAS OR STOOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. GENITOURINARY				
BLOOD IN URINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAIN WITH URINATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
STRONG URGENCY TO URINATE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FREQUENT URINATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INCOMPLETE EMPTYING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INVOLUNTARY/UNINTENDED URINE LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
URINE LOSS WHEN COUGHING OR LIFTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ABNORMAL BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAINFUL PERIODS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PREMENSTRUAL SYNDROME (PMS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAINFUL INTERCOURSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FIBROIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INFERTILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DES EXPOSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ABNORMAL VAGINAL DISCHARGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. MUSCULOSKELETAL				
MUSCLE WEAKNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Dr. E. Jones

HE HISTORY (Continued)

BIRTH DATE: / /

ID NO.:

DATE: / /

SYSTEMS (Continued)

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
8. MUSCULOSKELETAL (Continued)				
MUSCLE OR JOINT PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9a. SKIN				
RASH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SORES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DRY SKIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MOLES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9b. BREASTS				
PAIN IN BREAST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NIPPLE DISCHARGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
LUMPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. NEUROLOGIC				
DIZZINESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NUMBNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TROUBLE WALKING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SEVERE MEMORY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FREQUENT OR SEVERE HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. PSYCHIATRIC				
DEPRESSION OR FREQUENT CRYING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SEVERE ANXIETY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. ENDOCRINE				
HAIR LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HEAT/COLD INTOLERANCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ABNORMAL THIRST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HOT FLASHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. HEMATOLOGIC/LYMPHATIC				
FREQUENT BRUISES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CUTS DO NOT STOP BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ENLARGED LYMPH NODES (GLANDS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. ALLERGIC/IMMUNOLOGIC				
MEDICATION ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
IF ANY, PLEASE LIST ALLERGY AND TYPE OF REACTION:				
OTHER ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PLEASE LIST ALLERGY AND TYPE OF REACTION:				
FORM COMPLETED BY: <input type="checkbox"/> PATIENT <input type="checkbox"/> OFFICE NURSE <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> OTHER:				
SIGNATURE OF PATIENT:				
DATE REVIEWED BY PHYSICIAN WITH PATIENT: / /				PHYSICIAN SIGNATURE:
ANNUAL REVIEW OF HISTORY				
DATE REVIEWED: / /				PHYSICIAN SIGNATURE:
DATE REVIEWED: / /				PHYSICIAN SIGNATURE:
DATE REVIEWED: / /				PHYSICIAN SIGNATURE:
DATE REVIEWED: / /				PHYSICIAN SIGNATURE: