Ramon A. DeJesus, M.D., LLC

2012 Tollgate Road, Ste #100
Bel Air, Maryland 21015

Phone: 410-569-5155
Fax: 410-569-5166

Patient Questionnaire

Date:	PLEASE PRINT CLEARLY & RETURN WITH YOUR INS CARDS AND LICENSE TO RECEPTIONIST.	Date of Inury:

Patient Last Name	First Name	MI	Gender	Social Security #
Patient Address	City		State	Zip

Home #	Work #	Cell #	Marital Status	Date of Birth	Age
Employer Name	Employer Address		City	State	Zip
Emergency Contact Name	Relationship to Pt	Home #		Cell #	

E-mail Address:

Referred By (physician name)			Family Physician (Primary Care Physician)		
Address			Address		
City	State	Zip	City	State	Zip
Phone #	Fax #		Phone #	Fax #	

Workers Compensation (only complete if this is work related) If this section not applicable check here ____

Workers Comp Claim #	Date of injury	Employer Name	Employer Phone #

Insurance Information - Primary (these sections must be completed) ____ Patient did not have card

Insurance Company Name	Subscribers Name			Relationship to Patient
Insurance Company Address	City	State	Zip Code	DOB (if not pt) Social (if not pt)
Subscriber ID #	Insurance Grp #	Employer Name		Employer Phone #
Employer Address	City		State	Zip Code

Insurance Information - Secondary (these sections must be completed) ____ Patient did not have card

Insurance Company Name	Subscribers Name			Relationship to Patient
Insurance Company Address	City	State	Zip Code	DOB (if not pt) Social (if not pt)
Subscriber ID #	Insurance Grp #	Employer Name		Employer Phone #
Employer Address	City		State	Zip Code

PATIENT MEDICAL HISTORY - PLEASE PRINT CLEARLY

Date	Last Name	First Name	MI	Social Security #

Date of Birth	Age	Gender	Right or Left Handed	Occupation	Date of Injury

Where were you injured: (home, work, vehicle, other)	Location of injury (hand, finger, etc) L/R	Where were you injured?

Current Medications (LIST ALL PRESCRIPTION & OVER THE COUNTER MEDICATIONS INCLUDING VITAMINS, HERBS, ASPIRIN ETC)

Medication	Dose	Freq	Medication	Dose	Freq
Medication	Dose	Freq	Medication	Dose	Freq
Medication	Dose	Freq	Medication	Dose	Freq
Medication	Dose	Freq	Medication	Dose	Freq

Allergies & Reactions to Medications, Food & Latex

____No Known Drug Allergies ____Latex _____Food (specify) _____Other (specify)

Height	Weight	Have you ever had general anesthesia?	Have you ever had any problems w/ anesthesia? (describe)

Medical History - Please Check All That Apply & Explain Checked Items Below

Skeletal & Nerves	Heart & Lung	Other
_____Arthritis	_____Asthma, Bronchitis, Emphysema	_____Anemia
_____Elboy / Hand Injury	_____Chest Pain	_____Any Bleeding Disorder
_____Neck	_____Congestive Heart Failure	_____Blood Clot
_____Numbness / Tingling	_____Coronary Heart Disease / Angina	_____Cancer
_____Severe / Frequent Headaches	_____Heart Attack	_____Diabetes
_____Shoulder	_____High Blood Pressure	_____Emotional / Psychological Problems
	_____Pace Maker	_____Epilepsy / Seizures
	_____Shortness of Breath	_____Stroke / TIA
	_____Tuberculosis / Infectious Disease	_____Other

Explanation of Items Checked Above

Surgical History - List Most Recent Surgery First

Year	Surgery	Year	Surgery
Year	Surgery	Year	Surgery
Year	Surgery	Year	Surgery

Are you aware of your diagnosis?	What are your Goals / Expectations for your Therapy?

Patient Signature or Representative	Staff Signature

ATTORNEY INFORMATION (complete only if an attorney represents you)

IF THIS SECTION NOT APPLICABLE CHECK _____

Attorney's Name	Law Firm's Name	Phone #	Fax #
Address	City	State	Zip Code

RESPONSIBLE PARTY (COMPLETE ONLY IF RESPONSIBLE PARTY IS OTHER THAN PATIENT)

IF THIS SECTION NOT APPLICABLE CHECK _____

Last Name	First Name		MI	Relationship to patient?
Street Address	City	State	Zip Code	Social Security #
Home Phone #	Work Phone #	Employer Name of Responsible Party		Birth Date
Employer Address of Responsible Party	City		State	Zip Code

NURSING HOME INFORMATION

Nursing Home Name	Phone #
City	State	Zip

HOW WERE YOU REFERRED TO US?

Additional Person you wish us to share your Protected Health Information with.

Person's Relationship to You

Signature of Patient (or Responsible Party & Relationship if other than Patient)

Date