

Joe Ellis Wheeler, M.D., P.A.
750 8th Avenue, Suite 530
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New Patient

Please fill in the blank spaces below. This information will be placed in your chart. If you have difficulty with the questions, please leave it blank and ask the office staff for assistance.

Date _____

Patients
Name _____ Age _____ Gender _____
Last First Middle
Height _____ Weight _____

Address _____
Street City State Zip

Social Security Number _____

****Please note, this information does not leave our office.*****

Home Telephone _____

Work Telephone _____

Cell Phone _____

E-mail Address _____

Patient's Employer _____ Retired Y or N

Marital Status M S D W

Spouses Name _____ Parent's Name _____

If Under 18 Years old.

Occupation _____

Employers Address _____

Person to contact in case of emergency _____

Phone Number _____

I hereby authorize _____ Insurance Co. to pay directly to Dr. Joe Ellis Wheeler benefits due me under the terms of my policy. I hereby agree to pay any and all charges that exceed or that are not covered by my insurance.

Patient _____ Dated _____

Witness _____ Dated _____

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Insurance Information

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Group Health Plan Information (Patient's own coverage) - Work Comp. If you can attach a copy of your Insurance card, it will help us to verify benefits. If you are filing under Workers Compensation, you must complete this entire section.

Insurance Company _____
Phone _____

Address _____

Policy ID# _____ Group# _____

Insured Name _____

Insured's Date of Birth? _____ Effective Date _____

Are you currently employed? Y N

Employers Name _____

Phone _____

Employers Address _____

WORK COMP ONLY BELOW THIS POINT.

Claim# _____ Date of injury _____

Last day working? _____

Adjuster Name _____

Has this case been settled? Y N Lifetime Medical? Y N

Type of Injury reported? _____.

Were you injured on the job? Y N Date of Injury _____.

Were you involved in a motor vehicle accident? Y N

Seat Belt? Y N Air bag Deployed? Y N

Please explain if car accident occurred.

Are you under another physicians care at this time? Y N

Please circle all the studies you have had done in the past.

MRI CAT Scan X-Rays Myelogram EMG Bone Scan

Please circle the area of the studies.

Cervical (Neck) Lumbar (Back) Thoracic (Mid Back)

Brain (Head) Wrist

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Please describe in your words what is giving you problems or pain?

Past Medical History

Please list all of your allergies, including food and drug?

Are you allergic to IVP Dye or Latex? Y N

Please list all previous Surgeries? _____

Social History

Do you Drink alcohol? Y N How much? _____

How Often- Circle one? Daily Weekly Monthly Yearly

Occasionally

Do you drink Coffee Y N How Much _____.

Do you use Drugs? Y N What Kind? _____.

Do you smoke? Y N How Much? _____.

Family History

Please circle all family illnesses, diseases, etc...

******If answer is Yes to any, please list the relation. (mom, dad, sister, Etc...)**

Kidney trouble Y N

Heart Trouble Y N

Cancer Y N

Diabetes Y N

Stroke Y N

Other Y N _____.

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Please circle any of the following you are currently having any symptoms?

Blurring of Vision, Sight problems, Inflammation of eyes
Spots before your eyes, watering of eyes, itching of eyes,
Hearing loss ringing in ears, Trouble with Sinus,
Frequent colds, Nose Bleeds, Fever blisters, Sore Tongue
bleeding gums, hoarseness, Swelling of Neck, Pain when
moving neck, Headache, Dizziness, or Loss of Balance.

Do you have false teeth? Y N

Do you wear glasses? Y N

Do you have respiratory problems? Asthma, chronic bronchitis,
bad cough, etc...

Y N

Have you had any heart or cardiovascular problems in your past?
Palpitations, angiograms, swelling of feet or hands, etc...

Y N

If yes, please explain _____

Have you had any Gastrointestinal problems? Hernia, ulcers,
blood in stools, Polyps, etc.... Y N

If yes Please Explain _____.

Genitourinary System

Have you had blood in your urine, or burning?

Y N

If Yes, Please explain _____

Obstetrical History

How Many

Pregnancies? _____ Miscarriages? _____ Abortions? _____

How many living children? _____.

Ages _____.

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Neurological History

Please Circle all that apply.

**Previous Neck injury, Previous lower back Injury
Previous mid back Injury, Previous Head Injury,
Stroke, Hemorrhage, Seizures, Loss of Consciousness,
or Visual Disturbances.**

**WE NEED TO KNOW IF YOU HAVE BEEN PREVIOUSLY
OPERATED ON, IN ANY OF THE AREAS YOU HAVE CIRCLED
ABOVE.**

Y or N

Where _____.

Surgeon's Name _____.

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Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out by each patient annually.

Date _____

I authorize Drs. Smith and Wheeler. P.A. to release and receive any of my medical or insurance necessary to process my medical claims and coordinate or manage my health care. This may include all medical records or information regarding my treatment, Hospitalization, and/or out patient care for my condition. Including, but not limited to, psychological or psychiatric impairment, drug abuse, and/or alcoholism, sickle cell anemia, venereal disease, hepatitis, AIDS (acquired immune deficiency syndrome), AIDS related complex (ARC), and antibody testing.

In the event a family member or caregiver attends your office visits and is in the exam room at the time of the evaluation, and/or treatment. Do you give Drs. Smith and Wheeler or employees permission to **discuss freely** your condition, treatment, or diagnosis with that person? Y or N

Home Phone _____

May we Leave a Message? Y N

Work Phone _____

May we Leave a Message Y N

Cell Phone _____

May we Leave a Message Y N

E-mail _____

May we use this to help communicate with you? Y N

With whom may we discuss or release information about your care, Treatment or diagnosis? _____ Relationship _____

_____ Relationship _____

With whom may we **NOT** discuss or release information to?

_____ Relationship _____

Signature of Patient _____ Date _____

Witness _____ Date _____