

HOUMA
Orthopedic
CLINIC

A Medical Corporation

Appt. Time: _____

PLEASE PRINT CLEARLY

Date: _____

Name: _____ SS#: _____
 First M. Last

Address: _____ Date of Birth: _____
 Street City State Zip

Home Phone: _____ Cell Phone: _____ Sex: ___ Male ___ Female Age: _____

Employer: _____ Address: _____ Phone: _____

Occupation: _____ How Long? _____ Supervisor: _____

Married? ___ Yes ___ No Spouse's Name: _____ Employer: _____

Nearest relative not living with you: _____ Phone: _____

Landlord: _____ Phone: _____

If patient is a minor:
Parent/Guardian: _____ Address: _____ Phone: _____

Employer: _____ Address: _____ Phone: _____

Do you have medical insurance coverage? ___ Yes ___ No Insurance Co.: _____
Policy/Group Number

Is accident work related? ___ Yes ___ No Type of accident: _____ Date of injury: _____

WHAT HURTS? _____ Referred by: _____
(EXAMPLE: arm, knee, back)

For Office Use Only

DO NOT WRITE IN THIS SPACE

Bill To: _____

Verified By: _____

Address: _____

Insured/Claim # _____

City, State, Zip: _____

Phone # _____

A Medical Corporation

PATIENT QUESTIONNAIRE

Name _____ Date _____ Referring MD _____

Date of Birth _____ Age _____

Explain Purpose of Visit

Is this a work related injury? No Yes _____ Date of Injury

Auto Accident? No Yes _____ Date of Accident

Are you **allergic** to any medications? No Yes List medication _____

List all current **medications** you are on _____

Past Surgical History _____

Past Medical History (Circle any problems you have currently or in the past:)

- | | | | | | |
|----------------------|---------------|---------------------|----------|------------|-----------------|
| Fever | Pain at Night | Blood Clots | Bleeding | HIV | Hepatitis |
| Weight Loss | Cancer | High Blood Pressure | Fainting | Stroke | Reflux |
| Loss Bowel Control | Heart Attack | Angina/Chest Pain | Diabetes | Seizures | Ulcers |
| Loss Bladder Control | Circulation | Shortness of Breath | Asthma | Depression | Kidney Disorder |

Other: _____

Family History

Do bleeding disorders run in your family? No Yes

Do any diseases run in your family? No Yes, if yes: _____

Social History

Do you smoke? No Yes _____ packs/day _____ yrs

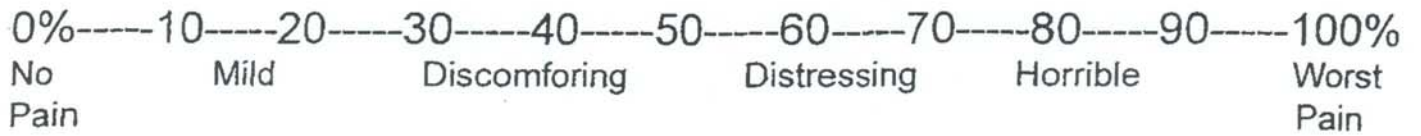
Do you drink alcohol regularly? No Yes _____ amount

Do you use illicit drugs? No Yes _____ amount

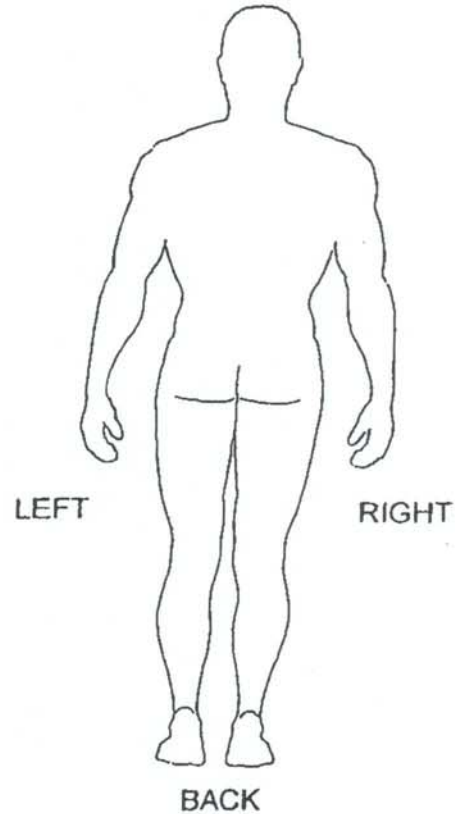
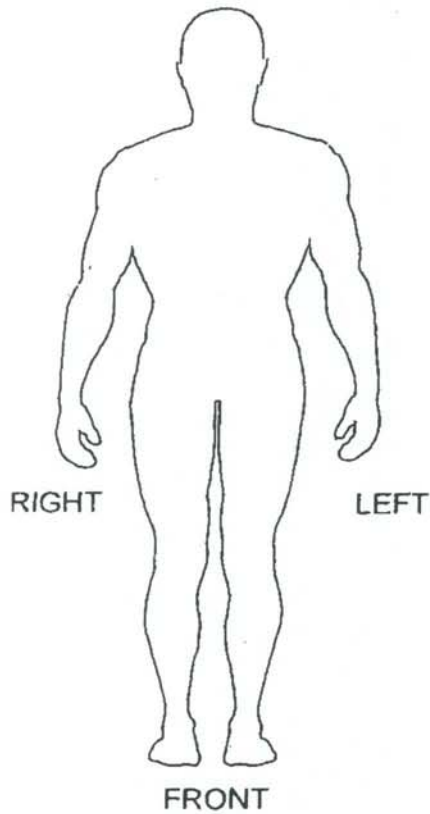
Are you currently working? No Yes _____ Date last worked

Describe Job _____

Pain Intensity Rating:



A ACHE	0 NUMBNESS	: PINS & NEEDLES
X BURNING	/ STABBING	



NAME : _____ DOB : _____

Houma Orthopedic Clinic: ACKNOWLEDGEMENT OF RECEIPT AND CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a courtesy you may list people below who you authorize access to your medical information pertaining to your treatment. You may revoke this authorization by contacting our office. We reserve the right to share information with family members or other persons, if in exercising professional judgment, we determine that doing so would be in the best interest of your patient care.

I authorize _____, (relationship to patient: _____)
access to medical information pertaining to my treatment.

I authorize _____, (relationship to patient: _____)
access to medical information pertaining to my treatment.

I authorize _____, (relationship to patient: _____)
access to medical information pertaining to my treatment.

Signed: _____

This Consent was signed by: _____
Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____

Date: _____ / /

In front of _____
Printed name – Practice representative

HOUMA ORTHOPEDIC CLINIC
A Medical Corporation

Patient's Name: _____ **Date of Birth:** _____

I understand office charges are payable at the time of service.

I understand there will be a fee for all NSF checks.

I understand if it becomes necessary to turn this account over to an outside collection agency, I will be responsible for any collection fees as well as all court costs and attorney fees incurred.

I understand after the insurance company pays, I am responsible for any outstanding balance. I AGREE TO PAY THE PHYSICIAN ALL CHARGES IN EXCESS OF INSURANCE REIMBURSEMENT.

I hereby authorize direct payment to HOUMA ORTHOPEDIC CLINIC, A Medical Corporation, any insurance payments for the medical and/or surgical bill.

I hereby authorize HOUMA ORTHOPEDIC CLINIC, A Medical Corporation, to release any information acquired in the course of my examination and/or treatment.

I hereby authorize any physician, hospital or medical facility to provide all information on my medical history and treatment to HOUMA ORTHOPEDIC CLINIC, A Medical Corporation.

I hereby authorize photocopies of this form to be valid as the original.

Date _____ Patient/Guardian's Signature _____