

HOUMA ORTHOPEDIC CLINIC
A Medical Corporation

Appt. Time: _____

Male _____

Full Name _____ Age _____ Female _____

Married Single Other Employed Full Time Student Part Time Student

Address _____ Cell Phone Number (____) _____

_____ Phone Number (____) _____

Date of Birth _____ Social Security Number _____ e-mail _____

Occupation _____ Employer's Name & Address _____

_____ Work Number (____) _____

Name of insured parent or guardian, if you are a minor _____

Insured Date of Birth _____ Sex _____ Social Security # _____

Spouse's Name _____ Employed By _____

In case of emergency, contact: Name _____ Phone _____
(someone other than persons living at your permanent address)

If someone other than the patient is responsible for payment, please list their name and address as well as phone number.

Do you have medical insurance coverage? _____ If yes, please give your INSURANCE CARD / MEDICARE CARD to the receptionist so that she may copy it for your file. If you are on **MEDICARE** and have a supplement insurance, write name of supplement here _____.

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 collection fees of 50% 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's Signature _____

Thank You



MEDICAL HISTORY

1. Please list any previous surgeries _____
2. List any previous or present illnesses _____
3. List allergies _____

PRESENT ILLNESS HISTORY

1. If you have been referred here by another doctor, please state his name and city. _____

2. What are you seeing the doctor for today? _____
3. Have you ever had this problem before? _____
4. Date of accident/injury _____
5. Where did it occur? _____
6. How did accident/injury happen? _____
7. Who, if anyone, has been treating you for this problem? _____

8. What treatment, if any, have you had? _____
9. List any medications you are taking and why _____
10. Have you had any x-rays for this problem? _____ When? _____
Where? _____
11. Have you had a CT Scan, Myelogram, or MRI for this problem? _____ When? _____
Where? _____

THIS FORM COMPLETED BY _____

HOUMA ORTHOPEDIC CLINIC

A MEDICAL CORPORATION

PATIENT HISTORY FORM

Name _____ Date _____

Occupation _____ Age _____

1. When (roughly what date) did your present pain start?

2. How did it start? (Check appropriate box)

- Lifting Pulling
 Twisting Hit in the back
 Fall Auto accident
 Bending No accident

3. Your pain is worse in your (Check appropriate boxes)

- Back Back and hip(s)
 Neck Down the leg(s)
 Head All of these
 Arm(s) None of these

4. How long have you been unable to work or do normal housework?

5. How long have you had any problem with your back, neck, legs or arms? (Circle appropriate parts) _____

6. Your pain is (Check appropriate boxes)

- | Better | Worse | No
Different | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | When coughing or sneezing |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sitting in a straight chair |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sitting in a soft easy chair |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bending forward to brush your teeth |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | When you wake up in the morning |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | In the middle of the night |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Midday |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lying flat on your back |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lying flat on your stomach |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lying on your side with your knees bent |

7. Do you have to rest during the day because of your pain? (Check appropriate box)

- No Half the day
 A little More than half the day

8. Have you ever been in a hospital for back, leg, neck, or arm pain?

Number of times _____

Give dates: _____

9. Have you ever had a myelogram (x-ray of the spine with dye injection)? _____

Number of times _____

Give dates: _____

10. Have you ever had an electromyogram (EMG)? _____

Number of times _____ Give dates _____

11. Have you ever had neck or back surgery? _____

Number of times _____

Give types and dates _____

12. Have you ever been in the hospital for other medical problems?

Number of times _____

Describe and give dates _____

13. Do you exercise on a regular basis?

- Yes No

14. Please list the medicines you are currently taking:

15. Do you now have or have you ever had

- | | Yes | No | | Yes | No |
|-----------|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Stomach problems, ulcer, etc. | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Heart problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Gout | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy (fits) | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> |

16. Please list any allergies you have _____

17. Do you have an attorney helping you?

- Yes No

18. Do you want a report sent to your attorney?

- Yes No

19. Do other members of you family have significant back or neck trouble? _____

Who (relationship)? _____

20. What treatments have made your pain better? _____

21. What treatments have made your pain worse? _____

22. What is the most aggravating thing about your pain? _____

23. Why did you come to this office? _____

24. Please add any other information you would like to include, or additions to your answers to previous questions. _____

PATIENT PAIN DRAWING

Name _____ Date _____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in your face.

Aching
▲ ▲ ▲

Numbness
= = =

Pins and needles
○ ○ ○

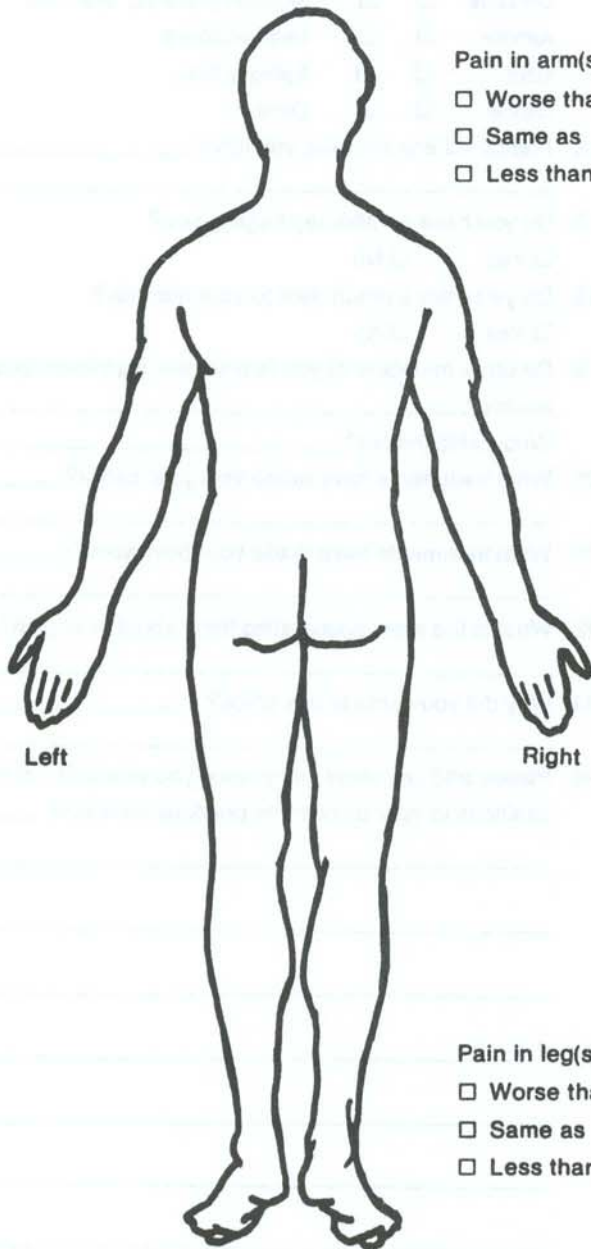
Burning
× × ×

Stabbing
/ / /

Other
● ● ●

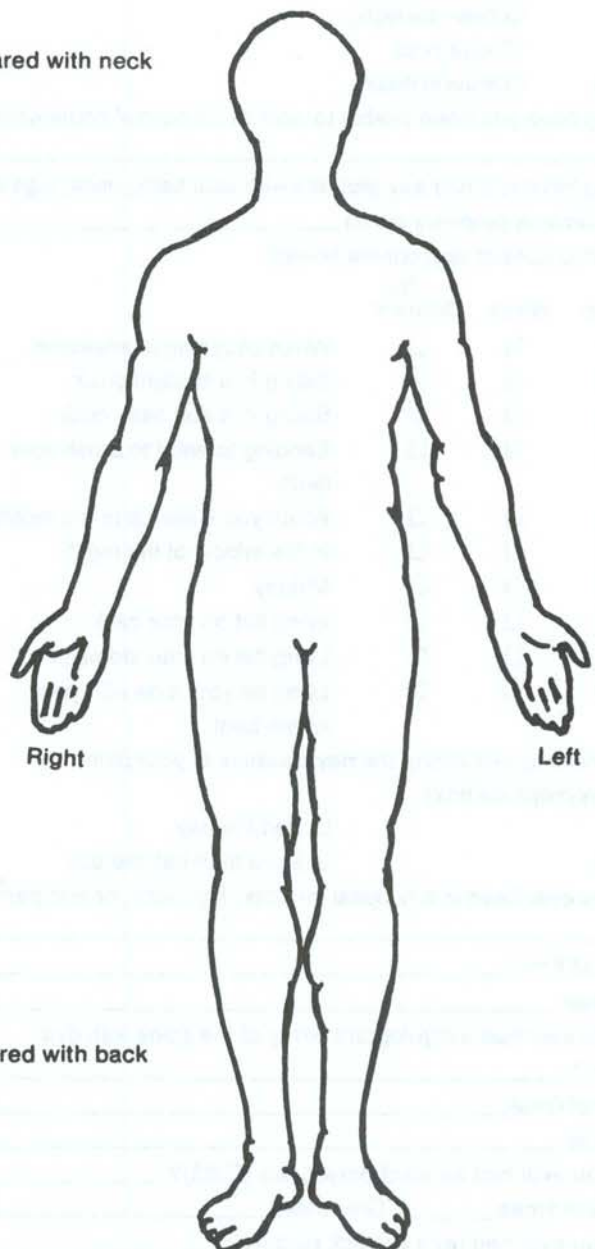
Back

Front



Pain in arm(s) compared with neck

- Worse than
- Same as
- Less than



Pain in leg(s) compared with back

- Worse than
- Same as
- Less than

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:** _____

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