* For office use only: Acct # _____ *

LOS™
LOUISIANA ORTHOPAEDIC SPECIALISTS

Please turn in the first THREE pages once completed

Patient Information

Patient Name (including MI):		Social Security Number:	
Address: Street	Date of Birth:	Sex: Female ☐ Male ☐	
City: State: Zip:	Cell Phone:	Home Phone:	Work Phone:
Email:	Preferred Method of Contact: ☐ Cell Phone ☐ Home Phone ☐ Work Phone		
Race: ☐ African American ☐ Asian ☐ Hispanic ☐ Caucasian ☐ Native American ☐ Other		Ethnicity: ☐ Hispanic ☐ Non Hispanic	
Employer:	Patients Occupation:		
If in High School, do you play sports? ☐ Yes ☐ No	If yes, please list the school: _____		

Person Responsible for Charges

Name:	Social Security Number:
Address: Street	Date of Birth:
City: State: Zip:	Contact Phone Number:
Employer:	Employer Phone Number:

If this is a job related injury, is this the employer you were working for at the time of injury? ☐ Yes ☐ No
If due to an injury, date of loss: _____/_____/_____
Will an attorney or Liability Carrier be involved in payment of charges? ☐ Yes ☐ No If yes, please explain: _____
If job related: Claim # _____ Case Manager: _____ Phone Number: _____

Referral Information

Primary Care Physician:	Name of Referring Provider:

Emergency Information: (In case of emergency, please notify the following)

Name:	Relationship:	Phone Number:
Address: Street	City:	State: Zip:

Insurance Information

Primary:		Secondary:	
Insured Name:	_____	Insured Name:	_____
Insured DOB:	_____	Insured DOB:	_____
Insurance Name:	_____	Insurance Name:	_____
Policy ID#:	_____	Policy ID#:	_____
Group/Account #:	_____	Group/Account #:	_____
Social Security #:	_____	Social Security #:	_____
Relation to Patient:	_____	Relation to Patient:	_____

I hereby certify the above information is true and correct to the best of my knowledge. I understand that while LOS contracts with many insurance companies, it is my responsibility to verify with my plan that LOS is a participating provider. It is also my responsibility to find out what my coverage options are with my insurance plan. I hereby authorize LOS to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of my insurance coverage. I acknowledge that photo ID's taken are used to assist in patient recognition per HIPAA guideline.

Patient Signature: _____ Date: _____

LOS™
LOUISIANA ORTHOPAEDIC SPECIALISTS

Privacy and Disclosure Statement

Your treatment, payment, enrollment, or eligibility for benefits of Louisiana Orthopaedic Specialists (LOS) is not dependent upon whether you sign this Privacy and Disclosure Statement. You have the right to revoke this Privacy and Disclosure Statement at any time by sending a written notice of revocation to LOS at 108 Rue Louis XIV, Lafayette, LA 70508; Attn: Privacy Officer. Our Practice Manager and front office staff will be glad to discuss these acknowledgements and authorizations with you.

By signing below, I acknowledge that I have received the Notice of Privacy Practices of LOS, which explains its legal duties and privacy practice with respect to my protected health information. I understand that if I have indicated my preferred method of contact is by cell phone, I may receive text message communications regarding my scheduled appointments, appointment reminders and missed appointment notifications. I understand that standard message and data rates may apply.

I understand if I choose to opt-out of receiving text message reminders, I am responsible for changing my preferred method of contact with LOS.

I hereby agree that LOS may disclose any and all of my protected health information to the following individuals, all of whom are involved in my care for any purpose related to my treatment or the payment of my care.

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Signature of Patient/Patient's Representative: _____ **Date:** _____

Printed Name of Patient/Patient's Representative: _____

LOUISIANA ORTHOPAEDIC SPECIALISTS

Financial Policy

Louisiana Orthopaedic Specialists (LOS) places its patients' needs first; however, we must be financially responsible to continue to serve.

- I understand that it is my responsibility to know my insurance benefits and plan coverage. My insurance may or may not cover the services provided at LOS. To obtain the most accurate information, please check with your insurance carrier to discuss the benefits provided by your medical plan prior to your visit to fully understand your anticipated out of pocket costs.
- I understand that co-payments, deductibles, co-insurance, and non-covered services are to be paid at or before the time of service. LOS accepts cash, checks, major credit cards, debit cards, HSA/FSA and Care Credit. You may also pay your bill online from the Patient/Bill Payment section of our website.
- I understand that I may be contacted by telephone regarding my outstanding balance with LOS.
- I understand that if I do not have my insurance and referral, and/or co-payment, that my appointment may be rescheduled until such time that I can provide the required documents or payments.
- I understand that LOS will collect, prior to any surgery or procedure, deductibles and coinsurance up to an amount equal to payment in full for the planned surgical procedure. Surgeries will include physician Assist fees that will be billed after your surgery. Payment in full and expected co-insurance payment responsibility are determined by the anticipated surgical billing code(s), details of your insurance policy, and agreement between your insurance company and LOS. If the full deductible is not applied to your claim by your insurance company LOS will refund any overpayment to you when we receive payment.
- I understand if my account has a patient responsibility amount that is not paid in full within 90 days then my account may be placed with an outside collection agency. No additional appointments will be made for delinquent accounts until they are brought current unless the appointment is of an urgent nature.
- I understand that a $35.00 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. Non-Sufficient Fund checks must be redeemed with certified funds (credit card or cash).
- I understand that I have until 5:00 pm the day before my appointment to cancel or reschedule. If I do not show up for my appointment and did not cancel in time, a $40.00 no-show fee will be charged to my account.
- I understand that there may be fees associated with medical records requests and completion of forms by a physician. I understand that I may be responsible for these fees.

Statement of Financial Responsibility: I acknowledge that I am responsible for all charges for services provided, including any amount not paid by insurance plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO), or any other payer. I have read and I understand the above Financial Policy and I agree to abide by its terms.

Patient or Guarantor Name: _____ **Relationship: _____**

Patient Signature: _____ **Date: _____**

LOUISIANA ORTHOPAEDIC SPECIALISTS

New Patient Medical History

Patient Name:	Height:	Weight:
Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Native American/Alaskan ☐ Pacific Islander ☐ Other ☐ Unknown ☐ Decline to Answer		
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Decline to Answer		
Preferred Pharmacy (With Address):		
Referral Source (Provider Name):	Other Referral Source (Ex: Google):	

Chief Complaint (What is the reason for your visit today?)

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Description of Symptoms (Please select only ONE primary symptom and ONE affected area that pertains to the reason for your VISIT TODAY.);

☐ Pain ☐ Numbness/Tingling ☐ Fracture ☐ Stiffness ☐ Other: _____

Shoulder	☐ Right	☐ Left		Pelvis	☐ Right	☐ Left		Neck ☐
Upper Arm	☐ Right	☐ Left		Hip	☐ Right	☐ Left		Upper Back ☐
Elbow	☐ Right	☐ Left		Thigh	☐ Right	☐ Left		Mid Back ☐
Forearm	☐ Right	☐ Left		Knee	☐ Right	☐ Left		Low Back ☐
Wrist	☐ Right	☐ Left		Lower Leg	☐ Right	☐ Left		Buttocks ☐
Hand	☐ Right	☐ Left		Ankle	☐ Right	☐ Left		Tail Bone ☐
Thumb	☐ Right	☐ Left		Foot	☐ Right	☐ Left		
Index	☐ Right	☐ Left		Great Toe	☐ Right	☐ Left		
Middle	☐ Right	☐ Left		2nd Digit	☐ Right	☐ Left		
Ring	☐ Right	☐ Left		3rd Digit	☐ Right	☐ Left		
Little	☐ Right	☐ Left		4th Digit	☐ Right	☐ Left		
				5th Digit	☐ Right	☐ Left		

Pain radiates from/to (Ex: low back to right leg.):

History of Present Illness

1. Is your problem the result of an injury of accident?

☐ No Injury ☐ Injury ☐ Injury at Work ☐ Auto Accident ☐ Sport Injury ☐ Prior Surgery

How long have the symptoms been present (Ex: two weeks, one month): _____

Describe the onset: ☐ Acute (sudden) ☐ Chronic Condition (greater than 3 months)

Onset Date (mm/dd/yyyy): _____

2. Are you represented by an attorney? ☐ Yes ☐ No If yes: Attorney Name: _____

Will there be any legal action with respect to this problem? ☐ Yes ☐ No

3. Have you had a problem like this before (affecting the same body part)? ☐ Yes ☐ No

Describe: _____

_____

History of Present Illness Cont.

4. Have you been seen in an ER for this problem? ☐ Yes ☐ No
Treating ER: _____ Date (mm/dd/yyyy): _____

5. Rate the pain (0 being no pain, 10 being the most pain):
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

6. Do the symptoms wake you from sleep? ☐ Yes ☐ No

7. Please describe the symptoms:
☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Shooting

8. What is the timing of the symptoms?
☐ Constant ☐ Intermittent (comes and goes)

9. Is the problem getting better or worse?
☐ Getting better ☐ Getting worse ☐ Unchanged

10. What makes the symptoms worse?
☐ Squatting ☐ Kneeling ☐ Sitting ☐ Bending ☐ Stairs ☐ Twisting ☐ Moving ☐ Lying in bed
☐ Running ☐ Walking ☐ Athletics ☐ Standing ☐ Gripping ☐ Lifting ☐ Reaching overhead

11. Are there any symptoms associated with this problem?
☐ Redness ☐ Bruising ☐ Swelling ☐ Numbness ☐ Stiffness ☐ Limping ☐ Clicking ☐ Locking
☐ Popping ☐ Tingling ☐ Weakness ☐ Giving way

Prior Testing/Treatment

Have you had any prior tests for this problem?
☐ None ☐ X-Rays ☐ MRI ☐ CT Scan ☐ Nerve Tests(EMG/NCV) ☐ Bone Scan

Have you had any prior treatment for this problem (if yes, please see below)? ☐ Yes ☐ No

Type of Treatment	Status of Symptoms after treatment (select only those that apply)			Date of Treatment
Ice	☐ Improved	☐ Worsened	☐ Unchanged	
Heat	☐ Improved	☐ Worsened	☐ Unchanged	
Rest	☐ Improved	☐ Worsened	☐ Unchanged	
NSAIDs	☐ Improved	☐ Worsened	☐ Unchanged	
Muscle Relaxers	☐ Improved	☐ Worsened	☐ Unchanged	
Chiropractor	☐ Improved	☐ Worsened	☐ Unchanged	
Physical Therapy	☐ Improved	☐ Worsened	☐ Unchanged	
Home Exercise Program	☐ Improved	☐ Worsened	☐ Unchanged	
Surgery	☐ Improved	☐ Worsened	☐ Unchanged	
Injections	☐ Improved	☐ Worsened	☐ Unchanged	
TENS Unit	☐ Improved	☐ Worsened	☐ Unchanged	

Other/Comments:

Previous Hospitalizations/Surgeries ☐ None

		Orthopedic on Side:	Right	Left
☐ Aneurysm (Brain) Surgery	☐ Hysterectomy			
☐ Aortic Bypass/Vascular Surgery	☐ LAP Band/Gastric Bypass Surgery	Arthroscopy: Knee	☐	☐
☐ Appendectomy	☐ Lumpectomy	Arthroscopy: Shoulder	☐	☐
☐ Cataract (Eye) Surgery	☐ Mastectomy	Carpal Tunnel Release	☐	☐
☐ Cholecystectomy (Gallbladder)	☐ Malignancy/Cancer	Rotator Cuff Repair	☐	☐
☐ Heart Surgery	☐ Stents	Total Hip Replacement	☐	☐
☐ Hernia Repair		Total Knee Replacement	☐	☐
Other Surgery: _____		Total Shoulder Replacement	☐	☐
_____		Spinal Surgery Level:		

Medical Questions

Mark all that currently apply:

☐ Metal in the Body ☐ Claustrophobic ☐ Pregnant ☐ Sleep Apnea ☐ Uses a CPAP ☐ Snores

Are you taking blood thinners (prescribed)? ☐ Yes ☐ No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last six months: ☐ None for all

				None	Comments
CON	☐ Weight Loss	☐ Loss of Appetite	☐ Fatigue	☐	
EYE	☐ Blurred Vision	☐ Double Vision	☐ Vision Loss	☐	
ENT	☐ Hearing Loss	☐ Hoarseness	☐ Trouble Swelling	☐	
CV	☐ Chest Pain	☐ Palpitations		☐	
RS	☐ Chronic Cough	☐ Pneumonia	☐ Shortness of Breath	☐	
GI	☐ Heartburn,Ulcers	☐ Nausea, Vomiting	☐ Blood in Stool	☐	
GU	☐ Painful Urination	☐ Blood in Urine	☐ Kidney Problems	☐	
SK	☐ Frequent Rashes	☐ Skin Ulcers	☐ Lumps ☐ Psoriasis	☐	
NEU	☐ Frequent Falls	☐ Loss of Coordination	☐ Numbness	☐	
PSY	☐ Change in Bowel	☐ Change in Bladder	☐ Dizziness	☐	
ENDO	☐ Depression/Anxiety	☐ Drug/Alcohol Addiction	☐ Sleep Disorder	☐	
HEM	☐ Fever	☐ Heat/Cold Intolerance	☐ Night Sweats	☐	
	☐ Easy Bleeding	☐ Easy Bruising	☐ Anemia		

Family History

Have any direct relatives had any of the following disorders? ☐ None for all

Father	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension
	☐ Bleeding Problems	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy
	☐ Stroke	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Cancer
	Comments:			
Mother	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension
	☐ Bleeding Problems	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy
	☐ Stroke	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Cancer
	Comments:			
Sibling	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension
	☐ Bleeding Problems	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy
	☐ Stroke	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Cancer
	Comments:			

Social History

Do you smoke (including but not limited to cigarettes, vapes, e-cigarettes, and pouches)?:

☐ Current, every day smoker ☐ Current, some day smoker ☐ Former smoker ☐ Never ☐ Heavy tobacco smoker ☐ Light tobacco smoker

Do you drink alcohol? ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Are you currently working? ☐ Yes ☐ No ☐ Retired ☐ Disabled **If no, what date did you work last?** _____

Please list any work restrictions, if any: _____

Occupation: _____ **Employer:** _____ **Student** ☐

Allergies

Do you have any allergies? ☐ Yes ☐ No **If yes, please list below:**

Medication, Relevant Food, or "Seasonal"		Reaction (number corresponds to allergy list)	
1. _____	8. _____	1. _____	8. _____
2. _____	9. _____	2. _____	9. _____
3. _____	10. _____	3. _____	10. _____
4. _____	11. _____	4. _____	11. _____
5. _____	12. _____	5. _____	12. _____
6. _____	13. _____	6. _____	13. _____
7. _____	14. _____	7. _____	14. _____

Latex Allergy? ☐ Yes ☐ No

Medications

Please list all medications below that you take on a regular basis: ☐ None

Do you currently have a prescription for medical marijuana? ☐ Yes ☐ No **If yes, what condition is it for?:** _____

Medications		Dosage & Frequency(ex: 5 mg, once a day; number corresponds to medications)	
1. _____	8. _____	1. _____	8. _____
2. _____	9. _____	2. _____	9. _____
3. _____	10. _____	3. _____	10. _____
4. _____	11. _____	4. _____	11. _____
5. _____	12. _____	5. _____	12. _____
6. _____	13. _____	6. _____	13. _____
7. _____	14. _____	7. _____	14. _____

Medical Conditions

Do you have a personal history of any of the following? ☐ None

☐ Aneurysm- Where:	☐ Emphysema	☐ Kidney Disease
☐ Angina (Chest Pain)	☐ Epilepsy	☐ Kidney Stones
☐ Arthritis- Type:	☐ Heart Attack	☐ MRSA Infection
☐ Asthma	☐ Hepatitis- Type:	☐ Pacemaker
☐ Bone or Joint Infections	☐ HIV/AIDS	☐ Phlebitis (Blood Clots)
☐ Cancer- Type:	☐ High Cholesterol	☐ Pulmonary Embolism
☐ Chemotherapy/Radiation	☐ Hypertension	☐ Reaction to Anesthesia- Type:
☐ COPD	☐ Hyperthyroidism	☐ Seizures
☐ Congestive Heart Failure	☐ Hypothyroidism	☐ Stomach Ulcers
☐ Diabetes- Type:	Last A1C:	☐ Stroke/TIA
		☐ Tuberculosis

Please list any other conditions or details of conditions marked above: _____

_____

Signature: _____ **Date:** _____