

PATIENT INFORMATION					
PATIENT NAME Last First M.I.				Social Security Number	
ADDRESS Street				DATE OF BIRTH	SEX Female Male
City	State	Zip	Home Phone	Cell Phone	Work Phone
EMAIL				Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Married	
PREFERRED METHOD OF CONTACT <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone					
RACE <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> Other				ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
EMPLOYER			PATIENTS OCCUPATION		
PHARMACY NAME			PHARMACY PHONE		
HOW DID YOU HEAR ABOUT US <input type="checkbox"/> Community Event <input type="checkbox"/> LOS Patient/Friend/Family <input type="checkbox"/> Employer <input type="checkbox"/> High School/Sport <input type="checkbox"/> Hospital/Urgent Care <input type="checkbox"/> Insurance <input type="checkbox"/> Magazine or Newspaper <input type="checkbox"/> Physician <input type="checkbox"/> Radio or Television <input type="checkbox"/> Website or Online					
PERSON RESPONSIBLE FOR CHARGES					
NAME			SOCIAL SECURITY NUMBER		
ADDRESS Street			DATE OF BIRTH		
City	State	Zip	CONTACT PHONE NO.		
EMPLOYER			EMPLOYER PHONE NO.		
If this is a job related injury, is this the employer you were working for at the time of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If due to an injury, date of loss: ____/____/____					
Will an attorney or Liability Carrier be involved in payment of charges? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____					
Is injury related to: <input type="checkbox"/> Accident <input type="checkbox"/> Job Related <input type="checkbox"/> Other: _____					
If job related: Claim # _____		Case Manager: _____		Phone No. _____	
REFERRAL INFORMATION					
PRIMARY CARE PHYSICIAN			NAME OF REFERRING PHYSICIAN		
EMERGENCY INFORMATION					
IN CASE OF EMERGENCY NOTIFY NAME		RELATIONSHIP		PHONE NO.	
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 IDs taken are used to assist in patient recognition per HIPPA guideline.					
Patient Signature: _____				Date: _____	

Your treatment, payment, enrollment or eligibility for benefits at 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 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 practices 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 of 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 (“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 the 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 coinsurance 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 overpayment.
- 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 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 p.m. 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 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 my 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: _____

NEW PATIENT MEDICAL HISTORY

Patient Name: _____	Height: _____	Weight: _____
Race: <input type="radio"/> African American <input type="radio"/> Asian <input type="radio"/> Caucasian <input type="radio"/> Native American/Alaskan <input type="radio"/> Pacific Islander <input type="radio"/> Other <input type="radio"/> Unknown <input type="radio"/> Decline to Answer		
Ethnicity: <input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic <input type="radio"/> Unknown <input type="radio"/> Decline to Answer		
Preferred Language: <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Chinese <input type="radio"/> Other: _____		
Preferred Pharmacy: _____		
Referral Source (Doctor Name): _____		Other (ex: Google): _____

Chief Complaint

Dominant Hand: Right Left Ambidextrous

Description of Symptoms: (select only ONE primary symptom and ONE affected area)

Pain Numbness/Tingling Fracture Stiffness Other: _____

Shoulder	<input type="radio"/> Right	<input type="radio"/> Left	Pelvis	<input type="radio"/> Right	<input type="radio"/> Left	Neck <input type="radio"/>
Upper Arm	<input type="radio"/> Right	<input type="radio"/> Left	Hip	<input type="radio"/> Right	<input type="radio"/> Left	Upper Back <input type="radio"/>
Elbow	<input type="radio"/> Right	<input type="radio"/> Left	Thigh	<input type="radio"/> Right	<input type="radio"/> Left	Mid Back <input type="radio"/>
Forearm	<input type="radio"/> Right	<input type="radio"/> Left	Knee	<input type="radio"/> Right	<input type="radio"/> Left	Low Back <input type="radio"/>
Wrist	<input type="radio"/> Right	<input type="radio"/> Left	Lower Leg	<input type="radio"/> Right	<input type="radio"/> Left	Buttocks <input type="radio"/>
Hand	<input type="radio"/> Right	<input type="radio"/> Left	Ankle	<input type="radio"/> Right	<input type="radio"/> Left	Tail Bone <input type="radio"/>
Thumb	<input type="radio"/> Right	<input type="radio"/> Left	Foot	<input type="radio"/> Right	<input type="radio"/> Left	
Index	<input type="radio"/> Right	<input type="radio"/> Left	Great Toe	<input type="radio"/> Right	<input type="radio"/> Left	
Middle	<input type="radio"/> Right	<input type="radio"/> Left	2 nd Digit	<input type="radio"/> Right	<input type="radio"/> Left	
Ring	<input type="radio"/> Right	<input type="radio"/> Left	3 rd Digit	<input type="radio"/> Right	<input type="radio"/> Left	
Little	<input type="radio"/> Right	<input type="radio"/> Left	4 th Digit	<input type="radio"/> Right	<input type="radio"/> Left	
			5 th Digit	<input type="radio"/> Right	<input type="radio"/> 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: 2 months): _____

Describe the onset: Acute (sudden) Chronic condition (>3 months)

Onset Date: (mm/dd/yyyy) _____

2. Are you represented by an attorney? Yes No

Attorney Name: _____

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

3. Have you had a problem like this before? Yes No

Describe:

4. Have you been seen in an ER for this Problem? Yes No

Treating ER: _____ Date (mm/dd/yyyy): _____

5. Rate the 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

History Present Illness (continued)

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? Yes No

Type of Treatment	Status of Symptoms after treatment (select only those that apply)			Date of Treatment
Ice	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Heat	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Rest	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
NSAIDs	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Muscle Relaxers	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Chiropractor	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Physical Therapy	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Home Exercise Prog.	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Surgery	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Injections	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Bracing	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
TENS unit	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Other/Comments: _____				

Previous Hospitalizations/Surgeries: None

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

Medical Questions

Mark all that currently apply:

- Metal in Body Claustrophobic Pregnant Sleep Apnea Uses a CPAP Snores

Are you taking blood thinners? Yes No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months: None for all

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

Family History

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

Father	<input type="radio"/> None	<input type="radio"/> Diabetes	<input type="radio"/> Heart Disease	<input type="radio"/> Hypertension
	<input type="radio"/> Bleeding Problems	<input type="radio"/> Epilepsy	<input type="radio"/> Connective Tissue	<input type="radio"/> Muscular Dystrophy
	<input type="radio"/> Stroke	<input type="radio"/> Osteoporosis	<input type="radio"/> Rheumatoid Arthritis	<input type="radio"/> Cancer
	Comments: _____			
Mother	<input type="radio"/> None	<input type="radio"/> Diabetes	<input type="radio"/> Heart Disease	<input type="radio"/> Hypertension
	<input type="radio"/> Bleeding Problems	<input type="radio"/> Epilepsy	<input type="radio"/> Connective Tissue	<input type="radio"/> Muscular Dystrophy
	<input type="radio"/> Stroke	<input type="radio"/> Osteoporosis	<input type="radio"/> Rheumatoid Arthritis	<input type="radio"/> Cancer
	Comments: _____			
Sibling	<input type="radio"/> None	<input type="radio"/> Diabetes	<input type="radio"/> Heart Disease	<input type="radio"/> Hypertension
	<input type="radio"/> Bleeding Problems	<input type="radio"/> Epilepsy	<input type="radio"/> Connective Tissue	<input type="radio"/> Muscular Dystrophy
	<input type="radio"/> Stroke	<input type="radio"/> Osteoporosis	<input type="radio"/> Rheumatoid Arthritis	<input type="radio"/> Cancer
	Comments: _____			

Social History

Do you smoke? 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 last work? _____

Please list 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
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Latex allergy? Yes No

Medications

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

Medications	Dosage and Frequency (e.g. 20 mg, once/day)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medical Conditions

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

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

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

Signature: _____ Date: _____