

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: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

**ALLERGIES**

Please list all allergies below:  None


**MEDICATIONS**

Please list all medications you are currently taking below:  None


**PAST SURGICAL HISTORY**

Please list all past surgeries or hospitalizations


**PATIENT PAST MEDICAL HISTORY**

<input type="checkbox"/> Anemia <input type="checkbox"/> Anxiety <input type="checkbox"/> Asthma <input type="checkbox"/> Bladder Infections <input type="checkbox"/> Blood Clots <input type="checkbox"/> Blood Disorders <input type="checkbox"/> Cancer Type: _____ <input type="checkbox"/> Chest Pain <input type="checkbox"/> COPD <input type="checkbox"/> Coronary Arterial Bypass <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Gout <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Migraines <input type="checkbox"/> Neurological Disorder <input type="checkbox"/> Neuropathy <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pacemaker	<input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Pregnant <input type="checkbox"/> Psychological Disorder <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Seizures <input type="checkbox"/> Shortness of breath <input type="checkbox"/> History of MRSA (staph infection) <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Stroke <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> Other: _____
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**FAMILY HISTORY**

Check one is someone in your family has/has any of the following

	Mother	Father	Sibling(s)	Grandparent(s)
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anesthetic Reaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

**SOCIAL HISTORY**

Occupation: \_\_\_\_\_ When was the last time you worked? \_\_\_\_\_  L Handed  R Handed

Restricted or light duty  Temporary  Permanent disability  Retired  Unemployed/Seeking Job

Are you currently under worker's compensation?  Yes  No

Is there an ongoing lawsuit related to today's visit?  Yes  No

Marital Status:  Married  Single  Divorced  Widowed

Tobacco:  No  Yes How many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_  Quit \_\_\_\_\_ yrs ago

Alcohol:  No  Yes How much do you drink daily? \_\_\_\_\_  Quit \_\_\_\_\_ yrs ago

Have you ever drank heavily or abused alcohol?  No  Yes

Drugs: Have you ever used any illicit substances?  No  Yes Type: \_\_\_\_\_

Have you ever been addicted to or misused prescription drugs?  No  Yes

**REVIEW OF SYSTEMS**

Are you currently experiencing any of the following?  check here if unknown

	Yes	No		Yes	No		Yes	No
<b>GENERAL</b>			<b>CARDIOVASCULAR</b>			<b>GASTROINTESTINAL</b>		
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Recent weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
Fever or chills	<input type="checkbox"/>	<input type="checkbox"/>	<b>EYES</b>			Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
<b>RESPIRATORY</b>			Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<b>NEUROLOGICAL</b>		
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
<b>KIDNEY/BLADDER/URINE</b>			<b>SKIN</b>			Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Frequent rashes	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Skin ulcers	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>			
<b>HEMATOLOGICAL/LYMPHATIC</b>			<b>ENDOCRINE</b>					
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>			
Easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Heat/Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>			
<b>PSYCHIATRIC</b>			<b>HEAD/EARS/NOSE/THROAT</b>					
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>			
Drug/Alcohol addiction	<input type="checkbox"/>	<input type="checkbox"/>	Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>			
Suicidal Thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>			

**PRESENT MEDICAL INFORMATION**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Type of pain:  Sharp  Dull  Unsure  Burning  Throbbing  Achy  Cramping  Stabbing  Other: \_\_\_\_\_  
(please circle one)  Dull  Frank  Traveling

What body part is involved? (please check all that apply)

	R	L		R	L		R	L
Ankle:	<input type="checkbox"/>	<input type="checkbox"/>	Arm:	<input type="checkbox"/>	<input type="checkbox"/>	Back:	<input type="checkbox"/>	<input type="checkbox"/>
Finger: _____	<input type="checkbox"/>	<input type="checkbox"/>	Foot:	<input type="checkbox"/>	<input type="checkbox"/>	Hand:	<input type="checkbox"/>	<input type="checkbox"/>
Knee:	<input type="checkbox"/>	<input type="checkbox"/>	Leg:	<input type="checkbox"/>	<input type="checkbox"/>	Neck:	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder:	<input type="checkbox"/>	<input type="checkbox"/>	Toe:	<input type="checkbox"/>	<input type="checkbox"/>	Wrist:	<input type="checkbox"/>	<input type="checkbox"/>
						Elbow:	<input type="checkbox"/>	<input type="checkbox"/>
						Hip:	<input type="checkbox"/>	<input type="checkbox"/>
						Pelvis:	<input type="checkbox"/>	<input type="checkbox"/>
						Other: _____		

How long ago did this problem start? \_\_\_\_\_  Days  Weeks  Months  Years

Were you seen in the ER for this problem?  Yes  No If yes, which ER? \_\_\_\_\_

On a scale of 0-10 (10 being the worst) how severe is your pain?

What is the quality of your pain: 12345678910

Do you have any of the following?  Bruising  Joint Instability  Hands Feel Clumsy  Locking/Catching  Weakness

Numbness  Poor Balance  Loss of Control of Bladder  Tingling  Swelling