Name:

Chart:

Date:

Welcome to the Baton Rouge Orthopaedic Clinic. We are committed to providing the best, most comprehensive orthopaedic care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks, if you need assistance filling out this form please notify the receptionist.

Demographics **Please print all information.**

Patient's Name:	Date of Birth:
Gender: ○ Male ○ Female	Age:

○ **I DECLINE TO RELEASE THIS INFORMATION AT THIS TIME.**

Race: (circle one) ○ American Indian ○ Asian ○ African-American ○ Native Hawaiian ○ Type-Unknown ○ Caucasian

Ethnicity Choices: ○ Hispanic Origin ○ Non-Hispanic ○ Type-Unknown

Preferred Language:	**Email Address:**

Address:

City:	State:	Zip Code:	Cell Phone
Social Security Number:	Drivers license number and state:		Home Phone
			Work Phone

If a minor name of guardian and relationship:	**Employer Name:**

Notify in Case of Emergency

Name:	Relationship:	Home Phone	Cell/Alternate Phone

Billing Information

Who is Responsible for the bill?

Primary Insurance Company: _____

Name of Subscriber: _____ Subscriber Date of Birth: _____

Primary Card Holder's SSN: _____

Secondary Insurance Company: _____

Name of Subscriber: _____ Subscriber Date of Birth: _____

Primary Card Holder's SSN: _____

○ **Self Payment** ○ **Responsible Attorney:** (Please Print) _____

Attorney Phone: _____

Problem Information

Is this injury work related: Yes ○ No ○ If YES, was the injury reported to the employer: Yes ○ No ○

Worker's Comp Contact Name: _____ Contact's Phone: _____

Details of Problem

Part of body to be checked: _____ How long have you had these symptoms: _____

Nature of problem: Other ○ Injury ○ Do you have x-rays: Yes ○ No ○ Date of Injury: _____

How did injury occur: _____

Please list all physicians seen for this problem: _____

Who can we thank for referring you to our clinic? _____

Who is your Primary Care Physician?

☐ **I do not consent to receiving automated calls, text messages, and/or email notifications to the contact numbers and email address provided for appointment reminders and other notifications.**

I hereby assign my insurance benefits plan for medical services rendered to Baton Rouge Orthopaedic Clinic. I understand that I am financially responsible for any charges not covered by this assignment; payment of all services rendered, regardless of insurance coverage or other third party liability; and pay all costs of collection, including reasonable attorney fees and court costs in the event it becomes necessary to pursue the account for collection. I also hereby authorize the release of information required in the course of my examination as may be needed to process my insurance.

Signature: _____ Date: _____

Name:

Chart:

Date:

Social History

Are you:	◯ Single	◯ Married	◯ Divorced	◯ Widowed	◯ Other
Living Arrangements:	◯ Home alone	◯ Home with Spouse	◯ Assisted Living	◯ Nursing Home	◯ Other

Smoking Status: ◯ Current every day smoker - If yes, _____ Pack(s)/day _____ Pack(s)/week _____ Number of years smoked

◯ Current some day smoker ◯ Smoker, current status unknown ◯ Never smoked

◯ Former smoked ◯ Unknown if ever smoked

Do you drink alcohol regularly? ◯ Yes ◯ No If yes, please list the amount and type ingested per day:_____

Family Medical History - Do you have a family history of any of the following illnesses? (Check all that apply)

Illness	Yes	Illness	Yes
Cancer		Rheumatoid Arthritis	
Heart Attack/Disease		Degenerative Arthritis	
High Blood Pressure		Thyroid Disease	
Diabetes		Immune Disorders	

Review of Systems - Are you experiencing any of the following? (Check all that apply)

	Yes		Yes		Yes
Constitutional Symptoms		**Gastrointestinal**		**Neurological**	
Recent weight change		Loss of Appetite		Frequent headaches	
Fever		Nausea or vomiting		Light headed or dizzy	
Unexplained sweating		Frequent diarrhea		Seizures	
Eyes		Constipation		Numbness or tingling	
Wear glasses or contacts		Rectal bleeding or blood in stool		Tremors	
Blurred or double vision		Black tarry stools		Paralysis	
Glaucoma		Regular abdominal pain or heartburn		**Psychiatric**	
ENT		**Genitourinary**		Memory loss or confusion	
Hearing loss		Frequent urination		Anxiety	
Regular nose or gum bleeding		Burning or painful urination		Depression	
Sore throat		Blood in urine		Insomnia	
Swollen glands in neck		Incontinence or dribbling		**Endocrine**	
Cardiovascular		Female: # of pregnancies		Glandular or Hormone Problem	
Irregular heart beats		Female: # of miscarriages		Excessive thirst or urination	
Shortness of breath w/walking or lying flat		**Musculoskeletal**		Heat or cold intolerance	
Swelling in feet, ankles, and hands		Joint pain		Changes in hair or nails	
Fainting spells		Joint stiffness and swelling		**Hematology**	
Elevated cholesterol		Morning stiffness		Bruising tendency	
Respiratory		Difficulty walking		Anemia	
Chronic or frequent coughing		Muscle cramping		Need for past transfusion	
Spitting up blood		**Integumentary**		**Patient: Please provide ht. & wt.**	
Regular shortness of breath		Rash or itching		Height _____	
Emphysema		Changes in skin color		Weight _____	
Regular wheezing		Varicose veins			

Allergies Do you have a history of latex allergy? Yes ◯ No ◯ Do you have a history of adhesive tape allergy? Yes ◯ No ◯

Drug	Reaction	Drug	Reaction
1.		3.	
2.		4.	

Past Surgical History

Year	Name of Operation	Type of Anesthetic (general, regional, local)	Complications

Name:
Chart:
Date:

General Medical History - Are you Affected by any of the following? (Check all that apply)

Illness/Injury	Yes	Illness/Injury	Yes
High Blood Pressure		Kidney disease	
Diabetes		Liver disease	
Heart attack/disease		Females ONLY: Are you or could you be pregnant?	
Chest pain or angina		AIDS or HIV Infection	
Stroke		Thyroid problems	
Cancer		Shortness of breath	
Hepatitis		Blood clots	
Stomach Ulcers		Bleeding tendency	
Arthritis		Pacemaker	
Gout		Accidents / Broken bones (please list)	
Osteoporosis			

Current Medications - Please list any prescription drugs, and/or non-prescription medications

Drug	Dosage	Drug	Dosage
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Do you take diet pills or nutritional supplements? Yes ○ No ○

If yes, please list the type and when last taken:

Name	Date Last Taken
1.	
2.	

Immunization History When was your last tetanus shot?

Medication History Patient Consent

I agree that Baton Rouge Orthopaedic Clinic may request and use my prescription medication history from other healthcare providers or third-party pharmacy payers for treatment purposes. **Yes** ○ **No** ○

Pharmacy

For filling prescriptions for all my medications prescribed by Baton Rouge Orthopaedic Clinic providers, I wish to use:

_____ Pharmacy, located at _____

NAME OF PHARMACY *STREET*

Phone ( )

_____ _____

CITY *STATE* *ZIP CODE* *AREA CODE* *TELEPHONE NUMBER*

I certify that to the best of my knowledge the preceding information is true and accurate.

_____ _____

Patient Signature (or parent if patient is a minor) Date

Name:
Chart:
Date:

Baton Rouge Orthopaedic Clinic, LLC

When you return this form to the receptionist **please bring your insurance card**. We cannot bill your insurance unless you give us your current, accurate insurance information.

As a courtesy to you we will bill your insurance company for services provided**. All co-payments and unsatisfied deductibles must be paid at time of service; our office expects payment in full from your insurance within 90 days unless otherwise specified by a contract with your insurance provider.** In the event that your insurance makes payment at a later date all overpayments will be refunded to you.

I have read and understand that I am ultimately responsible for all fees regardless of insurance coverage including any legal or other cost incurred in the collection of this account, if it becomes delinquent. I authorize Baton Rouge Orthopaedic clinic to release any medical information necessary to process insurance forms. I further authorize payment of medical benefits to Baton Rouge Orthopaedic Clinic.

Signed: _____ **Date:** _____

Acknowledgement of Receipt of Privacy Notice
Effective April 14, 2003

I have been presented with a copy of Baton Rouge Orthopaedic Clinic's **Notice of Privacy policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:

_____

Signed: _____ **Date:** _____

The person listed below has my permission to discuss my medical information:

Printed Name: _____ **DOB:** _____

Last 4 digits of SSN: _____

* This form will expire in one year.