LAFAYETTE BONE AND JOINT CLINIC

PATIENT INFORMATION

PLEASE PRINT Account#_____

TO SEE: (circle one) Dr. Blanda Dr. Hodges Dr. Muldowny Dr. Stubbs Dr. Sledge

NAME OF PATIENT: _____
Last First Middle

ADDRESS:_____
Number and Street, Apt.# City State Zip

SOCIAL SECURITY#_____ AGE:_____ DATE OF BIRTH:_____

SEX:_____M _____F MARITAL STATUS:_____M _____S DRIVERS LICENSE#_____

HOME PHONE# _____ CELL# _____ OCCUPATION _____

EMPLOYER:_____

EMPLOYER ADDRESS:_____ WORK PHONE#_____

SPOUSE'S NAME:_____

SOCIAL SECURITY#_____ AGE:_____ DATE OF BIRTH:_____

SPOUSE'S EMPLOYER:_____ OCCUPATION _____

EMPLOYER ADDRESS:_____ WORK PHONE# _____

EMERGENCY CONTACT:_____PHONE#_____
(NOT LIVING WITH YOU)

NEAREST RELATIVE OR FRIEND:_____PHONE#_____
(NOT LIVING WITH YOU)

REFERRED TO OUR OFFICE BY:_____PHONE#_____

HAVE YOU EVER BEEN TREATED BY:
Dr. Cobb___ Dr. Blanda___ Dr. Muldowny___ Dr. Hodges___ Dr. Stubbs___ Dr. Sledge___

IF YES, PLEASE EXPLAIN WHEN AND WHAT FOR:_____

_____

WHAT ARE YOU SEEING THE DOCTOR FOR?_____

DESCRIBE INJURY:_____

DATE OF INJURY:_____

WAS THIS CAUSED BY AN AUTO ACCIDENT?_____YES_____NO IS THIS A WORKERS' COMP INJURY?_____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?_____

DO YOU HAVE MEDICARE? YES _____ NO _____ MEDICARE NUMBER _____

IF WORKERS' COMP, IS IT A LOUISIANA OR TEXAS CLAIM LONGSHORE & HARBOR JONES ACT
(Please Circle One)

DO YOU HAVE AN ATTORNEY FOR THIS INJURY?_____YES_____NO

ATTORNEY'S NAME: _____PHONE# _____

NAME OF PATIENT:_____

****IF THE PATIENT IS A MINOR OR STUDENT, PLEASE COMPLETE****

MOTHER'S NAME:_____

ADDRESS:_____ HOME PHONE# _____

DATE OF BIRTH: _____OCCUPATION:_____ SS # _____

MOTHER'S EMPLOYER:_____WORK PHONE#_____

FATHER'S NAME:_____

ADDRESS:_____ HOME PHONE# _____

DATE OF BIRTH: _____OCCUPATION:_____ SS # _____

FATHER'S EMPLOYER:_____WORK PHONE#_____

INSURANCE INFORMATION

(Please give receptionist all insurance cards as proof of coverage)

1. INSURANCE COMPANY NAME_____

   ADDRESS _____

   INSURED'S NAME_____SOCIAL SECURITY #_____

   POLICY #_____GROUP #_____

2. INSURANCE COMPANY NAME_____

   ADDRESS_____

   INSURED'S NAME_____SOCIAL SECURITY #_____

   POLICY #_____GROUP #_____

3. INSURANCE COMPANY NAME_____

   ADDRESS_____

   INSURED'S NAME_____SOCIAL SECURITY #_____

   POLICY #_____GROUP #_____

Account # _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Lafayette Bone and Joint Clinic, Inc. or Dr. Sledge, Dr. Blanda, Dr. Hodges, Dr. Stubbs, and Dr. Muldowny to furnish any and all insurance company(s) or referring physicians all information they may request concerning my present illness or injury. I authorize the release of any medical or other information necessary to process my claim(s). I hereby assign to the provider all money to which I am entitled for medical and/or surgical expenses. Any credit balance will be refunded to the rightful party.

SIGNED: _____ DATE: _____

Patient or Parent

I authorize payment of medical benefits to the physician or supplier for services.

SIGNED: _____ DATE: _____

Patient or Parent

NAME OF PATIENT (Please Print Name): _____

ABOUT FINANCIAL ARRANGEMENTS AND INSURANCE

We are committed to providing you with the best possible care. If you have health insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

We request that office visits be paid at the time the service is rendered. To assist you, we accept cash, checks, MasterCard, or Visa. There will be a non-negotiable fee charged when a check is returned due to insufficient/uncollectible funds. A receipt for services rendered will be given to you that will have all information needed to file with your insurance company. Our office, accepting assignment of insurance benefits, will file surgery charges.

Accounts not paid in 90 days are subject to interest at the rate of 1.5% per month (18% annually). Returned checks may be subject to additional collection fees. If any account is placed in the hands of an attorney and/or collection agency for collection after default, the undersigned agrees to pay all cost of collection including a reasonable attorney's and/or collection agency fee.

Most companies generally consider our fees usual, customary and reasonable. This may not apply to companies who reimburse based on an arbitrary "schedule" of fees.

As health care providers, our relationship is with you, not your insurance company or a third party such as an attorney or liability insurance. All charges are your responsibility from the date the services are rendered. If temporary financial problems arise, we encourage you to contact us promptly for assistance in the management of your account.

Disclosure of Financial Interest (as required by LA. R.S. 37:1744)

In the course of treatment, it may be necessary that you be referred outside of Lafayette Bone & Joint Clinic for surgical/hospital services. For surgical or hospital services, you may be referred to Lafayette Surgical Specialty Hospital, Ambulatory Surgery Center of Opelousas and/or Practical Healthcare Supply, Inc., in which there exists a direct financial or economic interest. If you prefer that any of these services be arranged with another provider, please discuss this with the clinic personnel at the time the services are being arranged.

I have read all the above information.

SIGNED: _____ DATE: _____

Patient or Parent

LAFAYETTE BONE AND JOINT CLINIC

(A PROFESSIONAL MEDICAL CORP.)
1103 KALISTE SALOOM RD, SUITE 100 & 102
LAFAYETTE, LA 70508

PHONE: (337) 234-5234 FAX: (337) 235-2121

ORTHOPAEDIC SURGERY
JOHN E. COBB, M.D. (1945-2011)
LOUIS C. BLANDA, JR., M.D.
DAVID S. MULDOWNY, M.D.
MALCOLM J. STUBBS, M.D.
JOHN B. SLEDGE III, M.D.

PHYSICAL MEDICINE AND REHABILITATION
DANIEL L. HODGES, M.D.

AUTHORIZATION AND RELEASE

Insurers and managed care companies occasionally review medical charts to insure compliance with company procedures. I understand that my chart may be selected for such review and that the confidentiality of the information in my chart will be preserved and I hereby consent to such review and release this physician and any such insurer or managed care company from liability for any reasonable review of my chart.

_____ _____
Signature of Patient or Parent (if minor) Date

RELEASE OF MEDICAL RECORDS

I. TO: Drs. Cobb, Blanda, Hodges, Muldowny, Stubbs, and Sledge

I hereby authorize you to release to _____ any and all information including the diagnosis and records of any treatment or examination rendered to me by any of the above named physicians.

(attorney)

_____ _____
Signature of Patient Date

_____
Witness

II. Louisiana's Workers' Compensation law allows a healthcare provider to give the claimant's attorney a copy of all reports relating to the work injury without the claimant's authorization. (LA R.S. 23:1127) Unless you check below, we will send a copy of these reports to the last attorney you have identified. If you change attorneys you must notify us; until you notify us of the change, we will continue to send copies to your last attorney.

_____ No, do not send copies to my attorney _____
(Initials)

III. I, _____ hereby authorize Dr. John B. Sledge, Dr. Louis C. Blanda, Jr., Dr. Daniel L. Hodges, Dr. David S. Muldowny, Dr. Malcolm J. Stubbs, Dr. John B. Sledge III, and/or Lafayette Bone & Joint Clinic to release copies of my medical records and/or x-rays to any referring physician and/or my spouse, daughter, son, or anyone else that I have listed below.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Signature of patient Date

Lafayette Bone & Joint Clinic **Dr. Sledge**

Patient Information Sheet

****ENTIRE FORM MUST BE COMPLETY FILLED OUT****

Account #:_____

Today's Date:_____

Patient Name:_____ Age:_____ Date of Birth:_____/_____/_____

***(Physician)Primary Care Physician, Chiropractor, Lawyer, Physical Therapy, Other who referred you*:**

_____ Phone #:_____

Address:_____

****PLEASE SPECIFY RIGHT AND/OR LEFT WHEN DESCRIBING BODY PART PAIN (EX: RIGHT ANDKLE, LEFT ELBOW,LEFT LEG)**

1. Please describe the type of medical problem or symptoms that you are being seen for today:
   _____
   _____
2. Date and time your symptoms began:_____
3. If your symptoms were because of an accident or injury, circle one:
   Fall Trip Pedestrian Struck Bike Other.
   Please Explain:
   _____
   _____
4. If work injury, please describe circumstances:
   _____
   _____
5. Are you working now? _____ If not, date of last employment: _____/_____/_____
   - ☐ Long Term Disability, if so, what is the disability?_____ ___
   - ☐ Workers Comp while employed by? _____
   - ☐ Retired from? _____ ___
   - ☐ Work status? _____
   - ☐ Employed as? _____
6. The day of the injury, were you seen in the ER or by any other doctor, if so what treatment was done? Were you taken in by ambulance or drove yourself? Please describe the treatment that was done. Were able to return to work that day?
   _____
   _____
   _____
7. If MVA circle one of the following:
   Driver or Passenger Front seat or Back seat Seat belt or No Seat belt Air bags Car Drivable
   Were you taken to the hospital by ambulance or vehicle? _____
8. Please describe the circumstances of the accident:
   _____
   _____
9. If you're weak, please describe where. If you have pain please describe where.
   _____

What makes your condition worse? _____

What helps your condition? _____

Have you had any treatment for your current condition? Please circle one of the following:

Physical therapy:	Yes	No	Epidural Steroids:	Yes	No
Chiropractic Care:	Yes	No	Traction:	Yes	No

Other: _____

Did it help? _____

List any other test performed (circle any that apply): MRI X-Ray CT Nerve Test Other _____

CURRENT SYPTOMS CHECK LIST

Account #:_____

Patient Name: _____ Today's Date:_ _____

- **Head:**
  Headaches: Frequency _____ Where: _____
  Circle: Dizziness Nausea Vomiting Blurred vision Tinnitus Popping in jaw
  Grinding of teeth Difficulty swallowing Hoarseness
- **Neck:**
  Stiffness _____ Shocking _____ Swelling _____ Muscle Spasm _____ Throbbing _____
  Tingling _____ Aching _____ Sharp Pain _____ Weakness _____ Burning _____
  Numbness _____ Soreness _____ Stabbing _____
  Increased pain with (circle one): sitting standing walking driving/riding in vehicle
  flexion extension coughing sneezing lying down
  - Radiation pain: _____
- **Back:**
  Stiffness _____ Shocking _____ Swelling _____ Muscle Spasm _____ Throbbing _____
  Tingling _____ Aching _____ Sharp Pain _____ Weakness _____ Burning _____
  Numbness _____ Soreness _____ Stabbing _____
  Increased pain with (circle one): sitting standing walking driving/riding in vehicle
  flexion extension coughing sneezing lying down
  - Radiation pain: _____
  - Bladder/ Bowel: _____

- **Extremity** _____:
  Stiffness _____ Shocking _____ Swelling _____ Muscle Spasm _____ Throbbing _____
  Tingling _____ Aching _____ Sharp Pain _____ Weakness _____ Burning _____
  Numbness _____ Soreness _____ Stabbing _____
  Increased pain with (circle one): sitting standing walking driving/riding in vehicle
  flexion extension coughing sneezing lying down
  - ROM: _____ WNL: _____ Painful: _____ Limited: _____ Of _____
  - Legs: _____ Fatigue: _____ Gives way: _____
  - Hands/Arms: _____ Strength: _____

- **Extremity** _____:
  Stiffness _____ Shocking _____ Swelling _____ Muscle Spasm _____ Throbbing _____
  Tingling _____ Aching _____ Sharp Pain _____ Weakness _____ Burning _____
  Numbness _____ Soreness _____ Stabbing _____
  Increased pain with (circle one): sitting standing walking driving/riding in vehicle
  flexion extension coughing sneezing lying down
  - ROM: _____ WNL: _____ Painful: _____ Limited: _____ Of _____
  - Legs: _____ Fatigue: _____ Gives way: _____
  - Hands/Arms: _____ Strength: _____

- Sleeping: _____
- Rate the pain: _____ (0 best – 10 worst)

DR. JOHN B. SLEDGE
HISTORY OF PREVIOUS INJURIES

Detail of prior accidents or injuries (oldest first). Please complete in as much detail as possible.

ACCOUNT #: _____

PATIENT NAME: _____ DATE COMPLETED: _____/_____/_____

1) DATE OF INJURY: _____/_____/_____ TYPE OF INJURY (w/c, auto accident, other):
_____
BODY PART(S) INJURED: _____
DESCRIBE ACCIDENT (details please):
_____
_____
_____
DOCTOR(S) SEEN FOR THIS: _____
TYPE OF TREATMENT (pt, meds, testing, surgery) _____
Did you miss work? Yes No If yes, for how long? _____
Returned to work? Yes No If yes, date returned? ___/____/____
Did symptoms resolve? Yes No If no, describe problem: _____
_____

2) DATE OF INJURY: _____/_____/_____ TYPE OF INJURY (w/c, auto accident, other):
_____
BODY PART(S) INJURED: _____
DESCRIBE ACCIDENT (details please):
_____
_____
_____
DOCTOR(S) SEEN FOR THIS: _____
TYPE OF TREATMENT (pt, meds, testing, surgery) _____
Did you miss work? Yes No If yes, for how long? _____
Returned to work? Yes No If yes, date returned? ___/____/____
Did symptoms resolve? Yes No If no, describe problem: _____
_____

3) DATE OF INJURY: _____/_____/_____ TYPE OF INJURY (w/c, auto accident, other):
_____
BODY PART(S) INJURED: _____
DESCRIBE ACCIDENT (details please):
_____
_____
_____
DOCTOR(S) SEEN FOR THIS: _____
TYPE OF TREATMENT (pt, meds, testing, surgery) _____
Did you miss work? Yes No If yes, for how long? _____
Returned to work? Yes No If yes, date returned? ___/____/____
Did symptoms resolve? Yes No If no, describe problem: _____
_____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE. _____

(PATIENT'S SIGNATURE)

ACCOUNT #: _____

Current Family Doctor: _____ **Phone #:** _____
Address: _____
Specialist: _____ **Phone #:** _____
Address: _____

1. Do you now or have you ever had the following:

A) Heart problems	Yes	No	G) problems with Blood (i.e., clotting Problems)	Yes	No
B) Lung problems	Yes	No	H) Gastritis or Ulcers (Circle one or both if yes)	Yes	No
C) Kidney problems	Yes	No	I) Liver disease (such as hepatitis)	Yes	No
D) High Blood Pressure	Yes	No	J) Diabetes or problems with sugars	Yes	No
E) Anemia	Yes	No	K) Any type of cancer (if yes, please explain below)	Yes	No
Type of cancer: _____					
F) Neck problems	Yes	No	L) Back/Lumbar problems	Yes	No
Other: _____					

2. Please list all surgeries you have had, the surgeon, and the year they were performed:
   _____
   _____
   _____
   _____
3. Please list any medications that you are currently taking, list the name of the medications, the frequency, and the dosage:

   1._____ 5._____
   2._____ 6._____
   3._____ 7._____
   4._____ 8._____

4. **Are you allergic to any medications?** Please list the name of the medication and the reaction caused by taking the medication:
   _____
   _____

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced/Separated
- ☐ Widowed

Level of Education:

- ☐ Post Graduate Degree
- ☐ College Education
- ☐ High School Grad
- ☐ Highest Grade Completed

A) Tobacco	Yes	No	How much per day?_____	How many years? _____
B) Alcohol	Yes	No	How much per day?_____	How many years? _____
C) Illicit Drugs	Yes	No	How much per day?_____	
D) Herbal Supplements	Yes	No	How much per day?_____	

5. Has anyone in your **IMMEDIATE FAMILY** had, not including you, any of the following:

A) High Blood Pressure	Yes	No	If so, who?_____
B) Heart disease	Yes	No	If so, who?_____
C) Cancer	Yes	No	If so, who?_____
D) Diabetes	Yes	No	If so, who?_____
F) Stroke	Yes	No	If so, who?_____
G) Seizures	Yes	No	If so, who?_____
H) Migraine	Yes	No	If so, who?_____
I) Other (please list): _____			

6. What is your: Height: _____ Weight: _____
7. Are you (please circle): Right handed Left handed Ambidextrous

ACCOUNT #:_____

PATIENT NAME: _____

REVIEW OF SYSTEMS: Are you currently experiencing any of the following symptoms? Please check yes or no. May use space at the bottom of next page to explain if needed.

NO	YES	General
		Tiredness / Fatigue
		Lack of appetite
		Excess appetite
		Excessive Weight loss
		Excessive Weight gain
		Chills
		Fever
		Night sweats
		Difficulty in sleeping

NO	YES	Gastrointestinal
		Nausea
		Vomiting
		Diarrhea
		Constipation
		Heartburn
		Abdominal pain
		Bright red blood in stool
		Black stools

NO	YES	Eyes, Ears, Nose, Throat
		Pain in the eyes
		Difficulty in hearing
		Ringing in your ears
		Discharge from the ears
		Nasal discharge (frequent)
		Hoarseness

NO	YES	Urinary
		Incontinence of urine
		Pain or burning on urination
		Frequent urination-day
		Frequent urination-night
		Urinary tract infection
		Extreme urge to urinate
		Difficulty starting urinary stream
		Difficulty stopping stream
		Kidney stones

NO	YES	Cardiovascular
		Chest pain, tightness or squeezing
		Shortness of breath lying down
		Need to sit up to breath
		Heart racing
		Irregular heart beat (palpitations)
		Heart murmur
		Swelling of the legs
		Varicose veins
		Leg pain at rest
		Leg pain with exertion
		Blue/purple discoloration of: hands/feet

NO	YES	Musculoskeletal
		Muscle pain
		Neck pain
		Shoulder pain right or left
		Arm pain right or left
		Back pain
		Pain down your legs right or left
		Painful joints
		Swelling of any joints
		Redness of any joints
		Stiffness of any joints
		Deformities of the joints or extremities

NO	YES	Neurologic/Psychiatric
		Seizures
		Headaches
		Blackouts
		Dizziness
		Double vision
		Paralysis or weakness of limb(s)
		Loss of coordination
		Difficulty in speaking
		Nervousness
		Depression
		Difficulty in speaking
		Nervousness
		Difficulty with memory for past events
		Difficulty with thinking
		Difficulty with problem solving
		Blurred vision
		Spots before your eyes

NO	YES	Respiratory
		Cough
		Wheezing
		Asthma
		Shortness of breath at rest
		Shortness of breath with exertion
		Pain in the chest when you cough, sneeze, or move

PATIENT INITIALS: _____

ACCOUNT #:_____

You may use this section to further explain your "yes" answers above if needed.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of patient or person completing the form for patient.

_____

Relationship to patient

_____

Date

PATIENT INITIALS_____