LAFAYETTE BONE AND JOINT CLINIC

PATIENT INFORMATION

PLEASE PRINT

TO SEE: (circle one) Dr. Cobb Dr. Blanda Dr. Hodges Dr. Muldowny Dr. Stubbs Account#_____

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___

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. 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.
LOUIS C. BLANDA, JR., M.D.
DAVID S. MULDOWNY, M.D.
MALCOLM J. STUBBS, 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, and Stubbs

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 E. Cobb, Dr. Louis C. Blanda, Jr., Dr. Daniel L. Hodges, Dr. David S. Muldowny, Dr. Malcolm J. Stubbs, 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. Blanda

Patient Information Sheet

****ENTIRE FORM MUST BE COMPLETELY FILLED OUT****

Patient # _____ Account #_____

Today's Date:_____

Patient's Name: _____ **Age:_____ Date of Birth:_____/_____/_____**

Physician who referred you: _____ **Phone #** _____

Address: _____

Your Family Physician: _____ **Phone #** _____

Address: _____

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

1. Please describe the type of medical problem or symptoms that you are being seen for today: _____

   _____

   _____

2. Date your symptoms began: _____
3. If your symptoms were because of an accident or injury, please explain: _____

   _____

   _____

4. Are you symptoms getting worse, better or staying the same: _____

   If you have pain, numbness or tingling, please complete the following:

   Indicate **current** level of pain on the following scale: (No Pain) 1 2 3 4 5 6 7 8 9 10 (Intolerable)

   As best as you can, describe your symptoms in terms of:

   Location _____

   Does the pain move or radiate anywhere: _____

Timing of symptoms: (if applicable)	Description of symptoms:	Aggravators of symptoms:
_____Constant	_____Aches	_____Coughing
_____Occasional	_____Throbs	_____Sneezing
_____Wakes you up	_____Burns	_____Walking
_____With Activity	_____Tingles	_____Sleeping
	_____Stabbing	_____Bending or stooping
		_____Sitting

5. If you're weak, describe where and the degree of weakness: _____

   _____

   What makes your condition worse? _____

   What helps your condition? _____

   Other body parts affected: _____

   Have you had any treatment for your current condition? (circle one) Did it help?

   Physical Therapy: Yes No Epidural Steroids: Yes No

   Chiropractic Care: Yes No Traction: Yes No

   Other _____

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

   Has there been any change in bowel or bladder function: _____

6. 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 blood sugar	Yes	No

Cont. on Next Page ⇨

Patient # _____ **Account #_____**

e) Anemia Yes No
f) Neck problems Yes No
k) Any type of cancer (if yes, explain below) Yes No
l) Back/Lumbar problems Yes No

Other: _____

7. Please list all surgeries you have had including the year they were performed: _____

_____

_____

_____

8. 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. _____

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

_____

_____

10. a)Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

b)Work Status:
- ☐ Employed as _____
- ☐ Retired from _____
- ☐ Worker Comp while employed by _____
- ☐ Unemployed. Last employment and when _____
- ☐ Long Term Disability, if so, what is disability _____

Are you working now?_____ If not, date of last employment_____

11. Level of Education: ☐ Post Graduate degree ☐ College Education ☐ High School Grad ☐ Highest Grade Completed_____

12. Do you use:

a.	Tobacco	Yes	No	How much per day: _____
b.	Alcohol	Yes	No	How much per day: _____
c.	Illicit Drugs	Yes	No	How much per day: _____
d.	Herbal Supplements	Yes	No	How much per day: _____

13. Has anyone in your immediate family had:

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? _____
e.	Asthma	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):	Yes	No	If so, who? _____

14. Please provide the following information:

Mother: If living: Age: _____ If deceased: At what age and cause of death: _____

Father: If living: Age: _____ If deceased: At what age and cause of death: _____

15. Do you have any living siblings: If so, how many? _____ Brothers _____ Sisters

16. If you have deceased siblings:

Sex Age at Death Cause of Death:

____ _____ _____

____ _____ _____

17. Please provide the following information: Number of pregnancies: _____ Number of deliveries: _____
Number of living children: _____ Age of children: _____

18. If you have deceased children:

Sex Age at Death Cause of Death

____ _____ _____

____ _____ _____

19. What is your: Height _____ Weight _____

20. ☐ Right handed ☐ Left Handed ☐ Ambidextrous

Office Use Only
B.P.

Patient Name _____

20. REVIEW OF SYSTEMS: Are you currently experiencing any of the following symptoms? Please check yes or no. May use space at 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	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	Cardiovascular
☐	☐	Chest pain, tightness or squeezing
☐	☐	Shortness of breath lying down
☐	☐	Need to sit up to breathe
☐	☐	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	Gastrointestinal
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Heartburn
☐	☐	Abdominal pain
☐	☐	Bright red blood in stools
☐	☐	Black Stools

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

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

Patient Initials _____

NO	YES	Neurologic/Psychiatric
☐	☐	Seizures
☐	☐	Headaches
☐	☐	Blackouts
☐	☐	Dizziness
☐	☐	Double vision
☐	☐	Paralysis or weakness of limb (s)
☐	☐	Loss of sensation
☐	☐	Loss of balance
☐	☐	Loss of coordination
☐	☐	Difficulty in speaking
☐	☐	Nervousness
☐	☐	Depression
☐	☐	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

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

_____

_____

_____

_____

_____

Signature of patient or person completing form for patient

_____

Relationship to patient

_____

Date

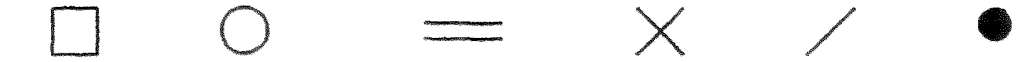
Patient Initials_____

PATIENT PAIN DRAWING

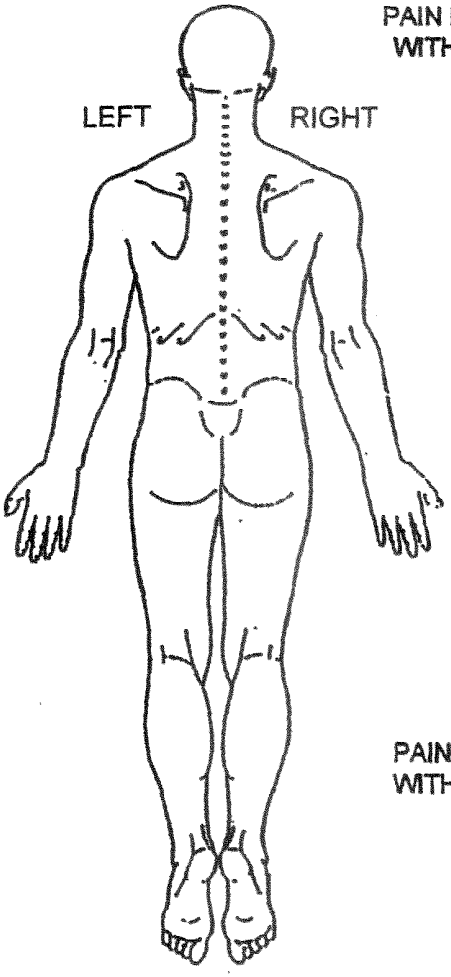
NAME:_____ DATE:_____

USING THE SYMBOLS GIVEN BELOW, MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. INCLUDE ALL AFFECTED AREAS. IT IS NOT NECESSARY TO USE ALL THE SYMBOLS, ONLY THE ONES WHICH MOST AFFECT YOU.

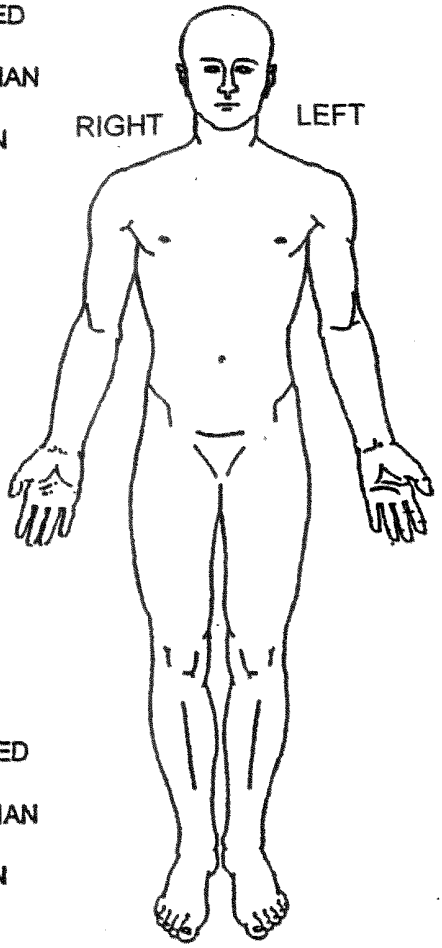
ACHING NUMBNESS PINS & NEEDLES BURNING STABBING OTHER



BACK FRONT



PAIN IN ARM(S) COMPARED WITH NECK:
WORSE THAN
SAME AS
LESS THAN



PAIN IN LEG(S) COMPARED WITH BACK:
WORSE THAN
SAME AS
LESS THAN

CIRCLE THE QUALITY OF YOUR PAIN 0 1 2 3 4 5 6 7 8 9 10
NORMAL UNBEARABLE

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

_____
PATIENT SIGNATURE

DR. LOUIS BLANDA, JR.

HISTORY OF PREVIOUS INJURIES

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

PATIENT NAME:_____ **DATE COMPLETED**_____

1.) DATE OF INJURY_____ TYPE OF INJURY (wc, 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 (wc, 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 (wc, 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