

PLEASE PRINT

LAFAYETTE BONE AND JOINT CLINIC

PATIENT INFORMATION

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# \_\_\_\_\_

RACE: \_\_\_\_\_ ETHNICITY \_\_\_\_\_ PREFERRED LANGUAGE: \_\_\_\_\_

HOME PHONE# \_\_\_\_\_ CELL# \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

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 \_\_\_\_\_

DO YOU HAVE BLUE CROSS? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES COMPLETE INSURANCE INFORMATION ON REVERSE

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# \_\_\_\_\_

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**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 # \_\_\_\_\_

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## AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

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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): \_\_\_\_\_

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### ABOUT FINANCIAL ARRANGEMENTS AND INSURANCE

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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.

Our office has implemented a two (2) business day "Cancellation Policy". If you need to cancel or re-schedule your appointment, please notify us two (2) business days prior to your scheduled appointment. Lack of prior notification will result in a **\$15.00 cancellation fee**. Please be advised, our office will NOT be able to reschedule your appointment until the \$15.00 cancellation fee is paid in full.

#### 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: \_\_\_\_\_

## 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

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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)

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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 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

Welcome to Lafayette Bone and Joint Clinic, office of Dr. Daniel Hodges. We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner. Below are a few guidelines and a reminder of what you will need to bring for your first visit:

- Bring any imaging that you have had performed within the last 6 months to a year, including x-rays, CT scans and MRIs. They **MUST** be brought to your appointment or it will be rescheduled.
- We will do our best to provide you with the best care. You will need to bring your insurance card and a photo ID with you for each appointment. Please let our staff know if you have had any information, address, or phone number changes since your last appointment.
- We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 30 minutes late. We will strive to stay on time. In the event of your appointment being late you will have the option to re-schedule or stay to be seen and we attempt to keep you informed of how long of a delay you may experience.
- Our office policy for a missed appointment is:
  - If it is an appointment for a new patient, the appointment will need to be rescheduled.
  - For each missed appointment there is a \$15 fee.
  - Two (2) no-show appointments may result in dismissal from the practice.
  - We understand that appointments sometime need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment.
- Dr. Hodges has asked that only the patient be seen in the examination room. Other guests, spouses, children 18 or older and friends are asked to stay in the waiting room. \*Please let us know if you require a caregiver to accompany you.\*
- Please do not use your cell phones once in the examination room. We strive to give everyone the best care and treatment; this is best done without distractions.

Welcome to our practice and thank you for choosing Lafayette Bone and Joint Clinic for all your health care needs.

**Please fill out the attached forms to the best of your ability. Please use details of any accidents or injuries.**

**All forms must be completely filled out in order to avoid rescheduling your appointment.**

New Patient Information Sheet

**\*\*\*Please complete and bring to your first appointment\*\*\***

Patient's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date Completed \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Injury \_\_\_\_\_ Who Referred you \_\_\_\_\_

Type of Injury (On the Job, car accident, fall, etc.) \_\_\_\_\_

Describe in detail when/how your pain began: (Please include the following – was it a fall, accident, or injury? What hurt? Did you have pain right after it happened? What did you land on, hit, have injured?) Use page 4 for additional information if needed.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you were in a work accident, please circle the following:

Did you notify your supervisor?      YES      NO

Was an accident report completed?      YES      NO

If you were in a car accident, please circle the following:

Were the police called?      YES      NO

Were you able to get out of the car?      YES      NO

Was the car able to start after the accident?      YES      NO      UNKNOWN

Did the airbags deploy?      YES      NO

Were you wearing your seatbelt?      YES      NO

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

\_\_\_\_\_  
PATIENT NAME

New Patient Information Sheet

Did you go to the hospital or seek treatment anywhere? (How did you get there? By ambulance, friend, drove yourself) \_\_\_\_\_

What hospital did you go to or where did you seek treatment? \_\_\_\_\_

How long after the accident did you go to the hospital or seek treatment? (Circle one)

Immediately      Couple hours later      Next day      Next week      Other: \_\_\_\_\_

Did the hospital do any of the following? (Circle all that apply)

X-rays      Give medication      CT scan      MRI      Surgery      Injection

Treatment (Circle all that apply)

Chiropractic Care: Yes No      Injections: Yes No      Physical Therapy: Yes No

Please list all surgeries and injections you had: (Include the year they were performed and the doctor's name)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have: High Blood pressure \_\_\_\_\_ Diabetes \_\_\_\_\_

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

\_\_\_\_\_  
PATIENT NAME



New Patient Information Sheet

What is your height: \_\_\_\_\_ What is your weight \_\_\_\_\_

Are you currently working? Yes No Retired Disabled Not working due to injuries

Circle which helps your symptoms: Ice Heat Rest Medication

Circle what makes your symptoms worse: Bending Sitting Standing Weather Changes

Do you have the following due to the pain? Depression Anxiety Sleeping problems

Describe your pain: Constant Come and Go

Since you last saw a doctor is your pain: Worse The same

Check all that describe your pain:

- Sharp       Aching       Stinging
- Dull       Burning       Throbbing
- Deep       Shooting
- Crampy       Stabbing

Allergies to Medication:

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I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

\_\_\_\_\_  
PATIENT NAME



# PATIENT PAIN DRAWING

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

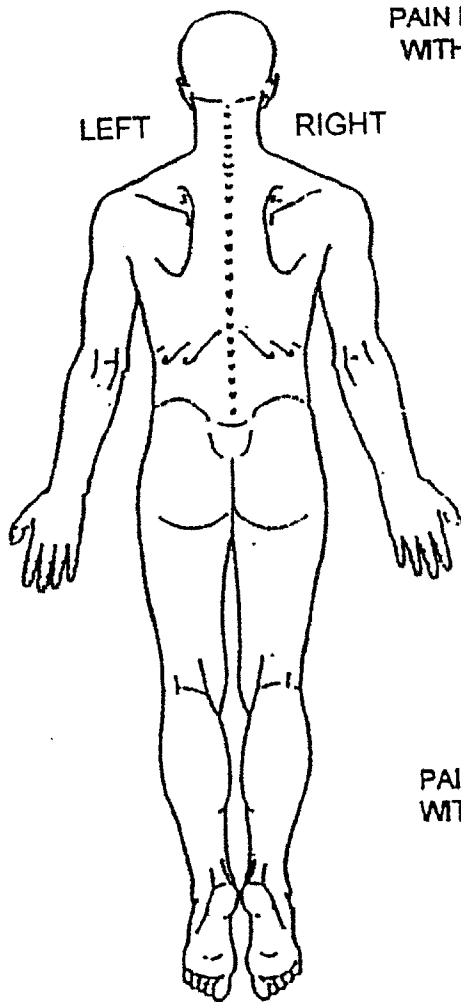
USING THE SYMBOLS GIVEN BELOW, MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. INCLUDE ALL AFFECTED AREAS. IT IS NOT NECESSARY TO USE ALL THE SYMBOLS, ONLY THE ONES WHICH MOST AFFECT YOU.

ACHING    NUMBNESS    PINS & NEEDLES    BURNING    STABBING    OTHER



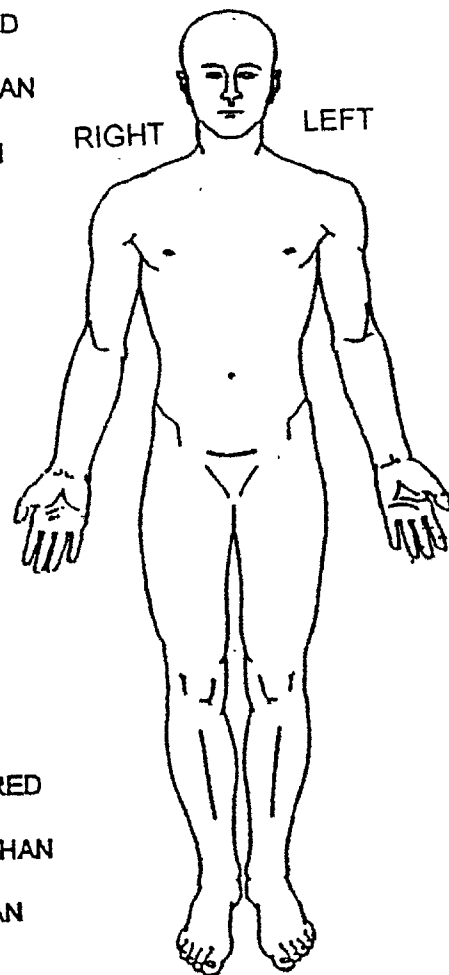
BACK

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