PLEASE PRINT IN INK

LAFAYETTE BONE AND JOINT CLINIC

PATIENT INFORMATION ACCOUNT #______________

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

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_____ Dr. Trahan_____

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 NEXT PAGE**

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. Blanda, Dr. Hodges, Dr. Stubbs, Dr. Muldowny, Dr. Sledge and Dr. Trahan 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.

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, Falcon Pharmacy LLC, 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: ______________

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.

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

NEUROLOGICAL SURGERY
JAYME TRAHAN, M.D.

AUTHORIZATION AND RELEASE

Insurers and managed care companies occasionally review medical charts to ensure 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, Sledge and Trahan.

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

______________________________ ______________________
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. Louis C. Blanda, Jr., Dr. Daniel L. Hodges, Dr. David S. Muldowny, Dr. Malcolm J. Stubbs, Dr. John B. Sledge III, Dr. Jayme Trahan 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

J:\user_folders\Simone Assistant\Forms\Doctors\All Doctors\Complete Patient Info. form\Patient Info Sheet - Part 2 - (With No Show Fee).doc

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

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: ______________________

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

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, circle one: **FALL** **TRIP** **Pedestrian Struck** **Bike**
   explain: ______________________

   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: ______________________

<u>If MVA circle one of the following:</u>

Driver or Passenger *Front seat or Back seat* *Seatbelt or NO Seatbelt* *Airbags deployed* *Vehicle Drivable*

Were you taken to the hospital by: Ambulance or Vehicle Same day as accident or Not same day of the accident

4. Please list all surgeries you have had including the year they were performed: ______________________

5. Please list any medications that you are currently taking. List the name of the medications, the frequency and the dosage:

6. **Are you allergic to any medications?** ______________________

7. What is your: Height ____________ Weight ____________

8. Are you currently working? Yes No Not working due to injuries

<u>Office Use Only</u>
B.P.

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

PATIENTS INITIALS__________

DR. JAYME TRAHAN

HISTORY OF PREVIOUS INJURIES

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

ACCOUNT #: ____________________

DATE COMPLETED ____________________

PATIENT NAME: ____________________

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

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
□	○	=	X	/	●

BACK

LEFT RIGHT

FRONT

RIGHT LEFT

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