

## Patient History Worksheet

This practice utilizes an electronic method of medical record keeping. This worksheet will assist our physicians and nurses in entering your medical history into your new electronic chart. As always, your personal information will be held in the most confidential manner. Please complete the following sections. *(check all that apply)*

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

### PAST MEDICAL HISTORY:

- |  |  |   |
|--|--|---|
| <input type="radio"/> None                             | <input type="radio"/> Diabetes, Type II  | <input type="radio"/> Osteoarthritis              |
| <input type="radio"/> AIDS/HIV                         | <input type="radio"/> Diverticular Disease   | <input type="radio"/> Osteopenia                  |
| <input type="radio"/> Alzheimer's Disease              | <input type="radio"/> Eczema   | <input type="radio"/> Osteoporosis                |
| <input type="radio"/> Anemia                           | <input type="radio"/> Emphysema  | <input type="radio"/> Parkinson's Disease         |
| <input type="radio"/> Anxiety Disorder                 | <input type="radio"/> Fractures  | <input type="radio"/> Peptic Ulcer Disease        |
| <input type="radio"/> Asthma                           | <input type="radio"/> GERD (Acid Reflux)   | <input type="radio"/> Peripheral Vascular Disease |
| <input type="radio"/> Bleeding Disorder                | <input type="radio"/> Gout   | <input type="radio"/> Polio                       |
| <input type="radio"/> Blood Clot                       | <input type="radio"/> Hemorrhoids  | <input type="radio"/> Renal Failure               |
| <input type="radio"/> CAD (Coronary Artery Disease)    | <input type="radio"/> Hepatitis: <input type="radio"/> (A) <input type="radio"/> (B) <input type="radio"/> (C) | <input type="radio"/> (RA) Rheumatoid Arthritis   |
| <input type="radio"/> Cancer                           | <input type="radio"/> High Cholesterol   | <input type="radio"/> Schizophrenia               |
| <input type="radio"/> Cancer (breast)                  | <input type="radio"/> Hypertension   | <input type="radio"/> Seizure Disorder            |
| <input type="radio"/> Cancer (skin)                    | <input type="radio"/> Kidney Disease   | <input type="radio"/> Sickle-Cell Anemia          |
| <input type="radio"/> Cataract                         | <input type="radio"/> Lung Disease   | <input type="radio"/> Sleep Apnea                 |
| <input type="radio"/> CHF (Congestive Heart Failure)   | <input type="radio"/> Lupus  | <input type="radio"/> Stroke                      |
| <input type="radio"/> Concussion                       | <input type="radio"/> Muscle Spasm   | <input type="radio"/> Thyroid Disorder            |
| <input type="radio"/> COPD (Chronic Pulmonary Disease) | <input type="radio"/> MVP (Mitral Valve Prolapse)  | <input type="radio"/> Tuberculosis                |
| <input type="radio"/> Depression                       | <input type="radio"/> Neuropathy   | <input type="radio"/> Valvular Heart Disease      |
| <input type="radio"/> Diabetes, Type I                 | <input type="radio"/> Obesity  | <input type="radio"/> _____                       |

### PAST SURGICAL HISTORY:

- None
- Adenoidectomy
- Appendectomy
- Bowel Resection
- Breast Surgery
- CABG (Heart Bypass)
- Carotid Endarterectomy
- Cataract Surgery
- Cesarean Section
- Cholecystectomy (GallBladder)
- Coronary Artery Angioplasty
- Hernia Repair
- Hysterectomy
- w/ Removal of one or both ovaries
- Lumpectomy
- Mastectomy (Breast Removal)
- Oophorectomy
- w/ Removal of one or both ovaries
- Placement of Stent \_\_\_\_\_
- Placement of Pacemaker
- Sinus Surgery
- Tonsillectomy
- TURP (Prostate)

### PAST ORTHOPAEDIC SURGICAL HISTORY:

- |   |   |
|---|---|
| <input type="radio"/> No History of Orthopaedic Surgery   | <input type="radio"/> Lumbar Spine Surgery  |
| <input type="radio"/> ACL Reconstruction: <input type="radio"/> L <input type="radio"/> R             | <input type="radio"/> Lumbar Laminectomy  |
| <input type="radio"/> Amputation  | <input type="radio"/> Nerve Repair  |
| <input type="radio"/> Arthroplasty (Total Replacement)  | <input type="radio"/> ORIF (Open Reduction Internal Fixation Fracture)                            |
| <input type="radio"/> Arthroscopy   | <input type="radio"/> Pin Fixation (fracture)   |
| <input type="radio"/> <input type="radio"/> Knee: <input type="radio"/> L <input type="radio"/> R     | <input type="radio"/> Rotator Cuff Repair   |
| <input type="radio"/> <input type="radio"/> Shoulder: <input type="radio"/> L <input type="radio"/> R | <input type="radio"/> Tendon Repair   |
| <input type="radio"/> Bunionectomy  | <input type="radio"/> Thoracic Spine Surgery  |
| <input type="radio"/> Carpal Tunnel Release: <input type="radio"/> L <input type="radio"/> R          | <input type="radio"/> Total Hip Replacement: <input type="radio"/> L <input type="radio"/> R      |
| <input type="radio"/> Cervical Spine (Neck) Surgery   | <input type="radio"/> Total Knee Replacement: <input type="radio"/> L <input type="radio"/> R     |
| <input type="radio"/> Disk Fusion   | <input type="radio"/> Total Shoulder Replacement: <input type="radio"/> L <input type="radio"/> R |
| <input type="radio"/> Excision (removal of mass, etc)   | <input type="radio"/> Trigger Finger Release  |
| <input type="radio"/> External Fracture Fixation  | <input type="radio"/> Ulnar Nerve Decompression   |
| <input type="radio"/> Fasciotomy  | Other:  |
| <input type="radio"/> Fracture Repair, of:  | <input type="radio"/> _____   |
| _____   | <input type="radio"/> _____   |
| _____   | <input type="radio"/> _____   |
| _____   | <input type="radio"/> _____   |
| <input type="radio"/> Joint Fusion, of  | <input type="radio"/> _____   |
| _____   | <input type="radio"/> _____   |
| _____   | <input type="radio"/> _____   |



Please indicate personal history within the last month or associated with today's complaint.

**CONSTITUTIONAL:**

Weight loss	No	Yes
Weight gain	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Pregnant	No	Yes

**EYES:**

Wears glasses or contacts	No	Yes
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**DENT:**

Headaches	No	Yes
Dentures	No	Yes
Dental problems	No	Yes
Gingival bleeding	No	Yes

**CARDIOVASCULAR:**

Chest pain	No	Yes
Irregular heart beats	No	Yes
Shortness of breath walking	No	Yes
Swelling of hands/feet	No	Yes

**RESPIRATORY:**

Abnormal sputum production	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes
Cough	No	Yes

**GASTROINTESTINAL:**

Loss of appetite	No	Yes
Nausea	No	Yes
Vomiting	No	Yes
Diarrhea	No	Yes
Constipation	No	Yes
Blood in stool	No	Yes
Abdominal pain	No	Yes

**HAVE THERE BEEN ANY RECENT UPDATES TO YOUR MEDICAL HISTORY (SINCE YOUR LAST APPOINTMENT):**

Allergies	No	Yes	If yes: _____
Medications	No	Yes	If yes: _____
Medical/Surgical History	No	Yes	If yes: _____
Surgical History	No	Yes	If yes: _____

**IS TODAY'S VISIT RELATED TO:**

Work related injury/illness	No	Yes	If yes: _____
Third party injury (auto accident)	No	Yes	If yes: _____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status.

\_\_\_\_\_  
Patient's Name - Please Print

\_\_\_\_\_  
Date

**GENITOURINARY:**

Frequency (urination)	No	Yes
Dysuria (painful urination)	No	Yes
Hematuria (blood in urine)	No	Yes
Incontinence	No	Yes

**INTEGUMENT:**

Rash	No	Yes
Itching	No	Yes
Pigmentation changes	No	Yes

**NEUROLOGIC:**

Tingling and numbness	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Light headed/dizzy	No	Yes

**MUSCULOSKELETAL:**

Joint pain	No	Yes
Joint swelling	No	Yes
Muscular weakness	No	Yes
Muscle pain	No	Yes
Back pain	No	Yes
Limitation of motion	No	Yes

**PSYCHIATRIC:**

Memory loss	No	Yes
Anxiety	No	Yes
Depression	No	Yes
Difficulty sleeping	No	Yes

**HEME-LYMPH:**

Easy bleeding	No	Yes
Easy Bruising	No	Yes
Cuts slow to heal	No	Yes
Anemia	No	Yes

\_\_\_\_\_  
Signature of Patient or Parent of Minor

\_\_\_\_\_  
Patient Date of Birth



**PATIENT INFORMATION FORM**

Patient Name: \_\_\_\_\_ Suffix: \_\_\_\_\_ Credentials: \_\_\_\_\_  
Preferred: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Sex: M [ ] F [ ] SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ DL#: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Marital Status: S [ ] M [ ] D [ ] W [ ] Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

**\*\* Fill out this section if patient is under the age of 18 or has a legal guardian \*\***

Responsible Party /Guarantor: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZipCode: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Preferred Pharmacy Name: \_\_\_\_\_ Pharmacy Location: \_\_\_\_\_

Bienville Physician: \_\_\_\_\_ Care Team: Primary: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Other: \_\_\_\_\_

**\*\* This section MUST be completed if patient is being seen for a Workers Compensation claim \*\***

Employers Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZipCode: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
DOB: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Insurance Information: (Please submit insurance cards for photocopy)**

**Primary Insurance**

Name of Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
Policy #: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Effective Date: \_\_\_\_\_  
Policy Card Holder: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
SS#: \_\_\_\_\_

**Secondary Insurance**

Name of Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
Policy #: \_\_\_\_\_  
Group #: \_\_\_\_\_  
Effective Date: \_\_\_\_\_  
Policy Card Holder: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
SS#: \_\_\_\_\_

We at Bienville Orthopaedic Specialists file Insurance as a courtesy to our Patients. However, any money not payable by your insurance company is the Patient's responsibility in accordance with their benefit plan.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## PATIENT AUTHORIZATION FORM

**PATIENT NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

### **Authorization To Use, Obtain and Disclose Health Information**

I have read and understand the Notice of Privacy Practices of Bienville Orthopaedic Specialists, LLC. I authorize Bienville Orthopaedic Specialists, LLC, to use, obtain and disclose specific health and medical information regarding my treatment for the purposes described to/from my insurance company, my primary care physician, area hospitals and facilities and other health care providers. I acknowledge that I am responsible for providing and updating my insurance, demographic, primary care physician as well as other care providers to Bienville Orthopaedic Specialists.

### **Policy on Use of Recording Devices by Patients in Our Offices**

To ensure confidentiality and privacy, any type of electronic recording is strictly prohibited within our offices at any of our locations. This includes any audio/video equipment or use of cell phones for recording purposes. The Health Insurance Portability and Accountability Act (HIPAA) grants privacy protection to patient's records

### **Authorization to Treat**

I hereby authorize the physicians and medical staff of Bienville Orthopaedic Specialists, LLC, to perform the necessary services I may need.

### **Permission To Give Medical Information**

I hereby authorize the physicians and staff of Bienville Orthopaedic Specialists, LLC, to give information concerning my health and well-being to the person(s) listed below. Including, appointment times, test/lab results, medication, procedures and any information regarding my health

- |                         |                         |
|-------------------------|-------------------------|
| 1. _____<br>(Full Name) | _____<br>(Relationship) |
| 2. _____<br>(Full Name) | _____<br>(Relationship) |
| 3. _____<br>(Full Name) | _____<br>(Relationship) |

### **Message/Answering Machine**

I hereby authorize Bienville Orthopaedic Specialists, LLC, to leave a message on the answering machine/voice mail.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient ID: \_\_\_\_\_



## Financial Policy

I understand that I am ultimately responsible for payment for services received from Bienville Orthopaedic Specialists (BOS) regardless of insurance coverage. BOS will submit claims for reimbursement to my insurance carrier; however, payment in full is ultimately my responsibility.

Initial payments and deposits are expected at the time of service. These payments may be for a co-pay, deposit, deductible or an existing balance. Again, payment may be required if it is determined that today's visit may not be reimbursed/covered by my insurance carrier or my deductible has not been met.

I understand any payment made by me is considered a deposit or payment on account and may not be payment in full. I will be billed for any balance not covered by my payment.

I understand that if I no show or cancel within 24 hours on two consecutive incidences then I will incur a \$25 lien placed on my account that must be paid prior to rescheduling my appointment. Continued attendance issues may constitute further repercussions.

I understand that BOS may deny me service and/or charge a service fee for failure to pay a co-payment at the time of service.

It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.

I can avoid interest charges by paying my bill immediately if required or by its due date.

I understand that I will be responsible for paying any interest fees, collection costs, attorney fees, and court costs that we may incur to settle my account up to the maximum of 33.3% of the balance in the event that my account is referred to a collection agency.

I authorize BOS and/or its designated provider to send electronic account statements to my email address on file and that I will not receive a mailed copy of any electronic statement.

I hereby assign to BOS all my interest to medical reimbursement benefits under my insurance policy. Furthermore, I attest that I have provided accurate and reliable insurance information to Bienville Orthopaedic Specialists. And, regardless of insurance coverage, I acknowledge that I am financially responsible for all services provided to me by BOS.

For Self-pay Patients, you will be responsible for payment of all services in full. Payment is expected at the time of service unless mutually agreed upon payment arrangements have been made with BOS prior to your appointment. You will also be responsible for any additional charges performed at the time of service.

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient ID#: \_\_\_\_\_



As a patient of Bienville Orthopaedics, you may be prescribed controlled substances. At time, controlled medications are useful and necessary to treat orthopedic complaints. Yet there is high potential for misuse and therefore closely monitored by local, state, and federal government. We must mutually agree to the following statements wherein "I" refers to the patient:

- 1) I am responsible for the safe placement of my controlled medication. If the medication is stolen, lost, misplaced it may not be replaced.
- 2) I am responsible for informing my physician(s) if I am receiving any controlled medications from other physicians.

Please list pain management physician's name (if applicable):

- \_\_\_\_\_
- 3) I will utilize one pharmacy to obtain my prescriptions.
  - 4) I understand the office refill policy is as follows:
    - a. Refill requests must be made during regular office hours.
    - b. Refill requests must be made 48 hours in advance.
    - c. Prescriptions must be picked up at designated location with photo ID.
    - d. Medication must be taken according to prescription instructions only.
    - e. Refills are not guaranteed and are at the discretion of the physician.
  - 5) I will not take sedatives, alcohol, or other pain medications without authorization from my physician. I will not use any illegal controlled substances including street drugs, marijuana, cocaine, etc.

Controlled substances are used to help me reach my treatment goals yet are known to cause dependence. I understand that the possible prescribing of this type of medication needs attention and management by the physician.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date Signed

Patient given copy of contract.

Date: \_\_\_\_ Initial: \_\_\_\_