BIENVILLE
Orthopaedic Specialists
The One To Trust

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:

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

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)
- ◯ Oopherectomy
- ◯ - w/ Removal of one or both ovaries
- ◯ Placement of Stent __________
- ◯ Placement of Pacemaker
- ◯ Sinus Surgery
- ◯ Tonsillectomy
- ◯ TURP (Prostate)

PAST ORTHOPAEDIC SURGICAL HISTORY:

- ◯ No History of Orthopaedic Surgery
- ◯ ACL Reconstruction: ◯ L ◯ R
- ◯ Amputation
- ◯ Arthroplasty (Total Replacement)
- ◯ Arthroscopy
  - ◯ Knee: ◯ L ◯ R
  - ◯ Shoulder: ◯ L ◯ R
- ◯ Bunionectomy
- ◯ Carpal Tunnel Release: ◯ L ◯ R
- ◯ Cervical Spine (Neck) Surgery
- ◯ Disk Fusion
- ◯ Excision (removal of mass, etc)
- ◯ External Fracture Fixation
- ◯ Fasciotomy
- ◯ Fracture Repair, of:

____
____
____
____

- ◯ Joint Fusion, of

____
____

- ◯ Lumbar Spine Surgery
- ◯ Lumbar Laminectomy
- ◯ Nerve Repair
- ◯ ORIF (Open Reduction Internal Fixation Fracture)
- ◯ Pin Fixation (fracture)
- ◯ Rotator Cuff Repair
- ◯ Tendon Repair
- ◯ Thoracic Spine Surgery
- ◯ Total Hip Replacement: ◯ L ◯ R
- ◯ Total Knee Replacement: ◯ L ◯ R
- ◯ Total Shoulder Replacement: ◯ L ◯ R
- ◯ Trigger Finger Release
- ◯ Ulnar Nerve Decompression

Other:

- ◯ ______________________
- ◯ ______________________
- ◯ ______________________
- ◯ ______________________
- ◯ ______________________
- ◯ ______________________

Patient History Worksheet

CURRENT MEDICATIONS:

Are you currently taking any medications from another physician? ◯ Yes ◯ No

Are you receiving pain medication (narcotics) from another physician? ◯ Yes ◯ No

*** If YES. List medications, dosage, frequency, and provider in the below medications section**

Drug Name / Strength	Dose	Frequency	Prescribed By
Example Drug Name 10mg	*2 capsules*	*Twice Daily*	*Dr. Example*

MEDICATION ALLERGIES:

- ◯ No Known Drug Allergies
- ◯ Ace Inhibitors
- ◯ Acetaminophen (Tylenol)
- ◯ Amoxicillin
- ◯ Aspirin
- ◯ Caine's (lidocaine, etc)
- ◯ Cephalosporins
- ◯ Codeine
- ◯ Demerol
- ◯ Erythromycin
- ◯ Lorcet
- ◯ Lortab
- ◯ Morphine
- ◯ NSAIDS
- ◯ Oxycontin
- ◯ Penicillin
- ◯ Percocet
- ◯ Percodan
- ◯ Phenytoin
- ◯ Sulfa
- ◯ Tetracycline
- ◯ Tylox
- ◯ Vicodin
- ◯ ____________________
- ◯ ____________________
- ◯ ____________________
- ◯ ____________________

Non-Medication Allergies:

- ◯ Allergy to Poultry / Eggs
- ◯ ____________________
- ◯ ____________________
- ◯ ____________________
- ◯ ____________________

FAMILY HISTORY: (Father, Mother, Brother, Sister)

- ◯ Non-contributory
- ◯ Adopted: Unknown Family History
- ◯ Anemia F[ ] M[ ] B[ ] S[ ]
- ◯ Anesthesia Difficulties F[ ] M[ ] B[ ] S[ ]
- ◯ Arthritis F[ ] M[ ] B[ ] S[ ]
- ◯ Bleeding Disorders F[ ] M[ ] B[ ] S[ ]
- ◯ Cancer F[ ] M[ ] B[ ] S[ ]
- ◯ Congenital Anomoly F[ ] M[ ] B[ ] S[ ]
- ◯ Diabetes F[ ] M[ ] B[ ] S[ ]
- ◯ Heart Disease F[ ] M[ ] B[ ] S[ ]
- ◯ Osteoarthritis F[ ] M[ ] B[ ] S[ ]
- ◯ Osteoporosis F[ ] M[ ] B[ ] S[ ]
- ◯ Rheumatoid Arthritis F[ ] M[ ] B[ ] S[ ]
- ◯ Stroke F[ ] M[ ] B[ ] S[ ]

ALCOHOL HISTORY:

- ◯ Current Every Day
- ◯ Current Some Days
- ◯ Former
- ◯ Never

TOBACCO HISTORY:
***REQUIRED IF 13 OR OLDER**

- ◯ Current Every Day
  Packs/Day: __________
- ◯ Current Some Days
  Packs/Day: __________
- ◯ Former
- ◯ Never
- ◯ Chewing Tobacco

OCCUPATION HISTORY:

- ◯ Disabled
- ◯ Employed
  Occupation (required): ____________________
- ◯ Homemaker
- ◯ Not Presently Employed
- ◯ Retired
- ◯ Self Employed
- ◯ Student

MARITAL STATUS:

- ◯ Divorced
- ◯ Engaged
- ◯ Married
- ◯ Separated
- ◯ Single
- ◯ Widowed

DOMINANT HAND:

- ◯ Ambidextrous
- ◯ Left Handed
- ◯ Right Handed

____

Patients Name (Printed) **Date of Birth**

____

Signature of Patient (or Authorized Signature: POA, Parent, etc...)

BIENVILLE
Orthopaedic Specialists

REVIEW OF SYSTEMS

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

HENT:

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

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

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 ____________

Signature of Patient or Parent of Minor ____________

Date ____________

Patient Date of Birth ____________

BIENVILLE
Orthopaedic Specialists
The One To Trust

PATIENT INFORMATION FORM

Patient Name: ______________________________ Suffix: ________ Credentials: ________
Last First MI

Preferred: ________ 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: ________

Updated 10.1.2020

BIENVILLE
Orthopaedic Specialists

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. ______________________ **(Full Name)** ______________________ **(Relationship)**

2. ______________________ **(Full Name)** ______________________ **(Relationship)**

3. ______________________ **(Full Name)** ______________________ **(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:____

Minor Child Treatment Release Form

In my absence, I, ______________________________, hereby give the following individual(s) permission to bring my child, ______________________________, to Bienville Orthopaedic Specialists to be treated for any medical condition.

I also authorize the Physicians, Nurse Practitioners, Physician Assistants, and staff to release any information including, but not limited to the diagnosis and the records of any treatment rendered to my child during the period of care to the names listed below.

Please include any family members, caregivers, coaches, or athletic trainers

______________________	______________________
Full Name	Relationship
Full Name	Relationship
Full Name	Relationship
Full Name	Relationship

I understand that as the parent, I may revoke the Minor Child Treatment Release Form at any time by providing written notice to the person or organization making the discosure.

______________________ ______________________
Minor Child (Print Full Name) Date of Birth (Minor Child)

______________________ ______________________
Signature (Parent or Legal Guardian) Date

Expires One Year From Above Date