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: _____

Preferred Method of Appointment Reminder(s): Text [ ] Voice [ ] None [ ] Patient Reminder Number: _____

** 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: _____

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		**Secondary Insurance**	
Name of Company:		**Name of Company:**	
Address:		Address:	
Policy #:		**Policy #:**	
Group #:		Group #:	
Effective Date:		Effective Date:	
Policy Card Holder:		**Policy Card Holder:**	
Relationship to Patient:		Relationship to Patient:	
Date of Birth:		**Date of Birth:**	
SS#:		**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: _____

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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: (**F**ather, **M**other, **B**rother, **S**ister)

◯ 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…)

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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.

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)
4. _____ (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:_____

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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 _____