

Acadiana Center for Orthopedic and Occupational Medicine, LLC

Paul Fenn, M.D.

204 Energy Parkway Suite B

Lafayette, LA 70508

Phone (337) 269-0136 Fax (337) 233-8525

PATIENT INFORMATION

PRINT

Patient's Name: _____ Cell #: _____
(Last) (First) (Mi)

Patient's Address: _____ Phone #: _____
Street City State Zip

Social Security #: _____ / _____ / _____ Age: _____ Date of Birth: _____ / _____ / _____

Sex: **M / F** Martial Status: **S M W D**

Patient's Employer: _____ Work Phone: _____
(If Minor, list Parent's Employer)

Alternate Contact Person: _____ Phone #: _____

Referred By: _____

Have you seen any of our physicians before or had any services at this clinic? _____ If yes, when and for what injury? _____

Reason for your visit today? _____
(Injury or Illness and body part)

Type of injury: **MOTOR VEHICLE ACCIDENT INJURED ON THE JOB LIABILITY NOT AN INJURY**

******* OFFICE USE ONLY *******

INSURANCE INFORMATION

VERIFICATION

Insurance Name _____

Effective Date _____

Insurance Phone # _____

Copay _____

Primary Card Holder _____

Coinsurance _____

Primary DOB: ____ - ____ - ____ SS# ____ - ____ - ____

ID / Policy # _____

Group # _____

Reason for visit? _____

Date Symptoms Began: _____

Responsible Party _____

Phone _____

Address: _____ City _____ State _____ Zip _____

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AUTHORIZATION FOR EVALUATION/TREATMENT AND RELEASE OF MEDICAL FORMS

I hereby authorize evaluation and treatment by the physicians of Acadiana Center for Orthopedic and Occupational Medicine. I authorize the release of my medical records and all information they may request concerning my treatment to my insurance company(s), attorney(s), vocational rehabilitation, and rehabilitation nurse(s). I authorize the release of this information to any doctor involved in my care. I also request that you release my medical records to the physicians of Acadiana Center for Orthopedic and Occupational Medicine.

In consideration of services rendered, I hereby irrevocably assign and transfer to the physician of Acadiana Center for Orthopedic and Occupational Medicine all rights, title and interest in and to the insurance benefits payable for services rendered provided in the referenced policy(s) of insurance. It is specifically understood that should a deficiency balance remain after the application of any and all insurance payments made to my account, that I shall be personally liable for the payment of this balance.

Should Acadiana Center for Orthopedic and Occupational Medicine retain an attorney, collector, or collection agency for the purpose of collecting any amount owed by me on my account, the undersigned further agrees to pay any and all costs of collection, including reasonable attorney fees and court costs.

Print Full Name _____

Signature _____ **Date** _____ **ID Checked by** _____
(Staff Initials & Date)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of this provider's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and will list any restriction(s) concerning my personal medical information.

List restrictions here:

In addition to myself, my health information and medical records may be released to the following person(s):

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ **Date:** _____

Notice of Privacy Practices

Paul E. Fenn, Jr., M.D.

Use and Disclosure of Medical Information

Medical history information, demographic information and financial information obtained during the course of your visit is kept by this office in the form of Medical Records. Without this information we could not meet your medical needs successfully. We value this information and understand that this information is confidential. Therefore, we have put in place safeguards to protect your personal health information from unauthorized access. The following information explains how this personal health information is used, when it is shared (disclosed), and when we require your consent to release this information.

- Treatment** ó Information is collected and documented regarding your care at each encounter. This information is used to keep track of changes in your condition, as well as remind us of your past care, treatment, allergies and other facts relevant to your overall health. This information may be shared with other healthcare professionals involved in your care.
- Payment** ó Information regarding your health care diagnoses and treatment is shared with your insurance carrier(s) to justify services for payment as necessary.
- Health Care Operations** ó In order to provide you with high quality healthcare and certain conveniences, we need to be able to use your personal health information. Examples of this would include such activities as admitting you to the hospital, arranging for diagnostic testing or calling in prescriptions. When conducting these activities, we are committed to providing only the needed information to accomplish the task.
- As Authorized by You** ó We will provide copies of your medical record, or parts of your medical record, as directed by you. This may be done verbally in person or by written authorization.
- As Required by Law** ó If we are required by law to provide your personal health information, we will abide by the law as written. Examples of this include: the required reporting of certain contagious diseases to public health agencies, for judicial proceedings or law enforced by subpoena, required reporting of abuse, neglect, or domestic violence, for workers compensation claims, as needed when donating tissue or organs, or to avert a serious threat to public health or safety.

Other uses and disclosures will be made only with your written authorization and you may revoke such authorization by writing to us at our practice address or delivering a written revocation to us in person.

Your Rights:

You have a right to request restrictions on the use and disclosure of your personal health information. Unfortunately, we may not be able to comply with all restrictions requested. If we believe we are able to comply with the restriction you have requested and therefore accept the restriction(s), we are committed to follow through with this request.

You have the right to inspect and have a copy of your personal health information. If you would like a copy, please notify the nurse or practice manager.

Patient History

Today's Date: _____ Height _____ Weight _____

Name: _____ Age _____ Date of Birth _____ Sex: M F

How did you learn about our office? _____

Physician who referred you: _____ Phone #: _____

Address: _____

Your family physician: _____ Phone #: _____

Address: _____

Are you currently being represented by an attorney regarding your injury or do you plan to seek legal assistance? Yes No

Please describe the type of medical problem or symptoms that you are being seen for today: _____

Date your symptoms began: _____

If your symptoms were because of an accident or injury, please explain: _____

Have you ever had a similar injury? _____ Are your symptoms getting worse, better, or staying the same: _____

Indicate the current level of pain on the following scale: (No pain) 1 2 3 4 5 6 7 8 9 10 (Intolerable)

As best you can, describe your symptoms in terms of: Location: _____

Does the pain move or radiate anywhere: _____

Timing of symptoms (if applicable)	Description of symptoms	Aggravators of symptoms
____ Constant	____ Aches	____ Coughing
____ Occasional	____ Throbs	____ Sneezing
____ Wakes you up	____ Burns	____ Walking
____ With activity	____ Tingles	____ Sleeping
	____ Stabbing	____ Bending or stooping
	____ Numbness	

If you are weak, describe where and the degree of weakness: _____

What helps your condition? _____

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 _____

Patient Name: _____

Have you had any of the following tests (circle those that apply): MRI X-ray CT Nerve Test Other _____

Has there been any change in bowel or bladder function? Yes No

Are you currently working? Yes No Have you missed any days? Yes No

Do you have now or have you had any of the following:

- | | | | | | |
|---------------------------------------|-----|----|--------------------------------|-----|----|
| a) Hypertension (high blood pressure) | Yes | No | g) Esophageal reflux | Yes | No |
| b) Coronary Artery Disease | Yes | No | h) Gastric ulcer | Yes | No |
| c) Asthma | Yes | No | i) Any type of cancer | Yes | No |
| d) Diabetes | Yes | No | j) Acute myocardial infarction | Yes | No |
| e) Epilepsy or seizure disorder | Yes | No | k) Thyroid disorder | Yes | No |
| f) Hepatitis or liver disorder | Yes | No | l) Stroke | Yes | No |
| Other: _____ | | | | | |

Please list any chronic conditions you have been treated for: _____

Please list all surgeries you have had and the year that they were performed: _____

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

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Do you have any food or drug allergies? _____

Family History: Has anyone in your immediate family ever had:

- | | | | |
|----------------------------|-----|----|-------------------|
| a) Coronary Artery Disease | Yes | No | If so, who? _____ |
| b) Myocardial Infarction | Yes | No | If so, who? _____ |
| c) Asthma | Yes | No | If so, who? _____ |
| d) COPD | Yes | No | If so, who? _____ |
| e) Thyroid disorder | Yes | No | If so, who? _____ |
| f) Diabetes | Yes | No | If so, who? _____ |
| g) Seizures | Yes | No | If so, who? _____ |
| h) Stroke | Yes | No | If so, who? _____ |
| i) Other (please list) | Yes | No | If so, who? _____ |

Social History:

Are you right-handed or left-handed? (Circle) Race: _____ Marital Status: S M W D

Education level: _____ Who lives in your home? _____

Do you use:

- | | | | |
|------------------|-----|----|-------------------------|
| a) Tobacco | Yes | No | How much per day: _____ |
| b) Alcohol | Yes | No | How much per day: _____ |
| c) Illicit Drugs | Yes | No | How much per day: _____ |

Occupation: _____

Patient Name: _____

REVIEW OF SYSTEMS: Are you currently experiencing any of the following symptoms? Please check yes or no.

NO YES GENERAL

- Headache
- Fever
- Chills
- Muscle aches
- Diffuse joint pain

NO YES HEENT

- Sore throat
- Hoarseness
- Earache
- Nasal symptoms
- Loss of hearing

NO YES CARDIOPULOMONARY

- Chest pain
- Shortness of breath
- Cough
- Difficulty breathing

NO YES GASTROINTESTINAL

- Nausea
- Vomiting
- Vomiting blood
- Diarrhea
- Constipation
- Red blood in bowel movement
- Red blood on the stool
- Diarrhea bloody
- Black or tarry stools

NO YES MUSCULOSKELETAL

- Muscle weakness
- Joint swelling, localized
- Neck pain
- Lower back pain
- Bone pain
- Joint pain, localized

NO YES NEUROLOGICAL

- Limb weakness
- Numbness
- Dizziness
- Fainting
- Confusion
- Speech difficulties
- Difficulties with balance
- Poor coordination

NO YES OTHER

- Skin symptoms
- Hematologic symptoms
- Endocrine symptoms
- Psychological symptoms

NO YES GENITOURINARY

- Blood in urine
- Genital lesion
- Vaginal discharge
- Abnormal urethral discharge
- Pain during urination
- Urinary loss of control
- Changes in urinary habits