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(A Medical Corporation)
PRACTICE LIMITED TO ORTHOPAEDIC SURGERY
ESTABLISHED IN 1951
www.northlaortho.com

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CHRIS DeMENT, ANP-C
LEE THOMAS,JR., PA-C

Dr.'s Name: ______________________

Patient Information	Patient #	Appt. Date	Social Security #	Driver's License #
First Name	Middle Name	Last Name	Sex M F	
Date of Birth	Age	Marital Status	Race/Ethnicity	Patient's Employer	Work Phone #
Patient's Mailing Address	City	State	Zip	
Patient's E-mail Address	Home Phone #	Cell Phone #	Spouse's Name	
Referring Doctor's Name	Referring Doctor's City, State			
Primary Insurance	Insurance Company Name	Insurance Company Address		
Insurance Group #	Insurance Policy #	Policy Holder's Name		
Policy Holder's Date of Birth	Policy Holder's Social Security #			
Secondary Insurance	Insurance Company Name	Insurance Company Address		
Insurance Group #	Insurance Policy #	Policy Holder's Name		
Policy Holder's Date of Birth	Policy Holder's Social Security #			
Guarantor Information (for children)	Guarantor's Name	Guarantor's Employer		
Guarantor's Phone #	Guarantor's Social Security #	Guarantor's Date of Birth		

Emergency Contacts:

(1) Name:	Phone:	Relationship:
(2) Name:	Phone:	Relationship:

ALL CHARGES ARE DUE IN FULL AT TIME OF TREATMENT

I declare that the above information is true and correct to the best of my knowledge.

I hereby make an irrevocable assignment of benefits or proceeds from any claim, health insurance, or worker's compensation in an amount sufficient to satisfy my indebtedness to the Orthopaedic Clinic of Monroe for services rendered for injuries sustained on or about ______________________ ,20 ________ .

I acknowledge receipt of the **Notice of Health Information Privacy Practices**.

Patient's Signature ______________________ **Date** ____________
(Parent or guardian, if minor)

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Doctor's Name________________________

Patient Name ______________________________ **Date** ______________

Date of Birth __________ **Age** __________ **Height** __________ **Weight** __________ **Sex** M F

CHIEF COMPLAINT

What part of the body are we checking today? ______________________

Please circle RIGHT or LEFT, if it applies to above question.

Date of injury or when symptoms began ______________________

Explain your problem ______________________

____

Have you been seen by another physician for this problem? **YES** **NO**

If yes, what physician and when? ______________________

Have you been seen at the emergency room for this problem? **YES** **NO**

If yes, what ER and when? ______________________

Have you been treated in the past for this condition? YES NO WHEN?________________________

X-RAYS

Have you had recent x-rays, scans, or MRI's taken that pertain to this problem? YES NO

If yes, when and where? ______________________

ALLERGIES YES NO If yes, please list below

Drug	Reaction	Drug	Reaction
1.		3.	
2.		4.	

DO YOU HAVE A HISTORY OF LATEX ALLERGY? YES NO

ARE YOU PREGNANT? YES NO

MEDICATIONS Include diet pills and/or nutritional supplements

Drug	Dosage	Drug	Dosage
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

YOUR Past Medical History

Illness	Yes	No	Illness	Yes	No	Illness	Yes	No	Illness	Yes	No
Hypertension			Diabetes			Osteoporosis			Stroke		
Angina			HIV			Gout			Renal Dialysis		
Heart Disease			Cancer			Sleep Apnea			Osteoarthritis		
Heart Failure			Rheumatoid Arthritis			Prostate Disorders			Please list any other		
Asthma			Esophageal Reflux			Renal Disorders					
COPD			Thrombophlebitis			Hepatitis			revised Jan '15		

Patient Name ______________________________ **Date** ______________

Date of Birth ______________

Please state your occupation and job duties. ______________________________

Social History

Are you: Single O Married O Divorced O Widowed O

Living Arrangements: Home Alone O Home with Family O Assisted Living O ______________

Nursing Home O ______________

Smoking/Smokeless Tobacco Status

Circle which applies:

Never Smoked Current Smoker Former Smoker Smokeless Tobacco Unknown

The amount and how often you use tobacco: ______________________________

Do you drink alcohol? Regularly O Occasionally O No O

If regularly or occasionally, please list the amount and type ingested: ______________

Do you use recreational drugs? Yes O No O

Were you referred here? If so, by whom: **Family Doctor:**

FAMILY Medical History (Do you have a family history of any of the following illnesses?)

Yes	No	**Illness**	If yes, then please list the type family member (i.e. father, mother, grandmother,etc.)
		Cancer	
		Heart Disease	
		Hypertension	
		Osteoarthritis	
		Diabetes	
		Rheumatoid Arthritis	
		Tuberculosis	

PAST SURGICAL HISTORY

Year	Name of Operation	Year	Name of Operation
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Review of Systems

	Yes	No		Yes	No		Yes	No
Systemic Symptoms			Night sweats			**Skin Symptoms**		
Weight change			Wheezing			Pruritus (itching)		
Chills			**Cardiovascular Symptoms**			Skin lesions		
Fever			Chest pain or discomfort			Rashes		
Night sweats			Fast heart rate			**Endocrine Symptoms**		
Malaise (feeling tired/poorly)			Palpitations			Excessive sweating		
HEENT Symptoms			**Gastrointestinal Symptoms**			Excessive thirst		
Headache			Difficulty swallowing			**Hematological Symptoms**		
Eyesight problems			Heartburn			Easy bleeding		
Nosebleeds			Nausea			Easy bruising tendency		
Neck Symptoms			Vomiting			**Neurological Symptoms**		
Neck Pain			Abdominal Pain			Dizziness		
Neck Stiffness			Diarrhea			Vertigo		
Lump or swelling in neck			**Genitourinary Symptoms**			Motor disturbance		
Pulmonary Systems			Blood in urine			Sensory disturbance		
Shortness of breath			Painful urination			**Psychologic Symptoms**		
Cough			Increased urinary frequency			Sleep disturbances		
Coughing up blood			Decreased kidney function			Anxiety		
						Depression		

What is your pharmacy name and address? ______________________________