North Louisiana
Orthopaedic & Sports Medicine Clinic

Experience You Can Trust Since 1951

Doctor'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 Email 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 # _____ Policyholder's Name _____

Policyholder's Date of Birth _____ Policyholder's Social Security # _____

Secondary Insurance

Insurance Company Name _____ Insurance Company Address _____

Insurance Group # _____ Insurance Policy # _____ Policyholder's Name _____

Policyholder's Date of Birth _____ Policyholder'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 _____

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 workers' compensation in an amount sufficient to satisfy my indebtedness to North Louisiana Orthopaedic & Sports Medicine Clinic for services rendered for injuries sustained on or about _____, 20_____.

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

_____ _____

Patient's Signature
(Parent or Guardian, if Minor)

Date

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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, which 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 MRIs 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					

Patient Name _____ Date _____

Date of Birth _____

Please state your occupation and job duties. _____

Social History

Marital Status ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Living Arrangements ❒ Home Alone ❒ Home With Family ❒ Assisted Living ❒ Nursing Home

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 ❒ Occasionally ❒ No

If regularly or occasionally, please list the amount and type ingested. _____

Do you use recreational drugs? ❒ Yes ❒ No

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 of 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.	

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Review of Systems

Patient Name _____ Date _____

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

What is your pharmacy name and address? _____

North Louisiana Orthopaedic & Sports Medicine Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability, or sex.

PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our office financial manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- The patient is always responsible for payment of any applicable co-pay, co-insurance, and/or deductibles at the time of his/her visit. However, as a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor (in other words you agree to have your insurance pay the doctor directly). If your insurance company does not pay the practice within a reasonable length of time (i.e. within 45 days) you will be responsible.
- With few exceptions (i.e. PPO Contracts), your insurance policy is a contract between you and your insurance company, the doctor is not involved.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. For other services, such as X-rays, fracture care, durable medical equipment supplies, etc., these claims are processed under your major medical with all applicable deductibles and co-insurance to be collected at the time of service.
- **If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.**
- If you have insurance coverage with a plan that we do not have a prior agreement we will prepare and send the claim form for you. Therefore our charges for your care and treatment are due at the time of service.
- Unless you have made other arrangements in advance, full payment is due at the time of service. For your convenience, we will accept VISA, MasterCard, Discover and AMEX. We also offer CareCredit as a means of paying your bill.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “not covered”; you will be responsible for the complete charge.
- For all services provided by our physicians in the hospital, we will bill your health plan. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred.
- There is a $35 fee charged for each disability form completed by our office and for disability continuation forms the fee is $15.
- In order to provide the best possible service and availability to all our patients please call us as early as possible if you know you need to reschedule your appointment. There is a $50 No Show or same day cancellation fee on our MRI appointments.
- I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____

Signature of Patient or Responsible Party if Minor Date

_____

Please Print Name of Patient Account Number

Revised June 2021