Name:
DOB:
Chart:
Age:
Date: Guar Acct #:

PONTCHARTRAIN ORTHOPEDICS & SPORTS MEDICINE

Ticket #:_____

PATIENT INFORMATION

Patient: _____ (Last / First / Middle) Title: Mr./Mrs./Other: _____ Suffix: Jr./Sr./Other: _____

Mailing Address: _____ Zip _____ City _____ State _____

Physical Address: _____ Zip _____ City _____ State _____

Home #: _____ Work #: _____ Ext: _____ Cell #: _____ Other: _____

Email: _____ Date of Birth: _____

Social Security #: _____ Sex: ☐ Male ☐ Female ☐ Unknown ☐ Other

Marital Status: Married Single Widowed Divorced (circle one)

Preferred Language: ☐ English ☐ Spanish ☐ Unknown ☐ Decline to specify ☐ Other: _____

Race: ☐ Caucasian/White ☐ African American/Black ☐ Unknown ☐ Decline to specify ☐ Other: _____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown ☐ Decline to specify

Current Employer: _____

Employment Status: Fulltime Self Employed Part Time Not Employed Unknown Retired Military Active (circle one)

Student: Full Time or Part Time (circle one) Prior Name: _____

Emergency Contact (EC) Name: _____ Relationship: _____

Home #: _____ Work #: _____ Cell #: _____

Pharmacy: _____ Address: _____ Phone #: _____

Notification Method: Mail Email Phone (circle one) Patient & Resp Party are the same? Yes or No (circle one)

Blood Type: _____ Referred By: _____

Do you have an advanced directive (living will, durable power of attorney)? Yes or No → If 'Yes', provide copy:

Rec'd by: _____ Date: _____

Is this an Accident or Injury? Yes or No Work Related? Yes or No If 'Yes' to either question, request and complete an Accident/Injury Information Form

Are you currently a Hospice or Home Health Care patient or are you in a Nursing Home or Skilled Nursing Facility? Yes or No

If 'Yes', request a Hospice/HHA/NH/SNF Facility Information Form and ask about an ABN Form

RESPONSIBLE PARTY INFORMATION

ONLY COMPLETE IF OTHER THAN PATIENT, THIS IS WHERE STATEMENT/BILL IS SENT AFTER INSURANCE DISPOSITION

Responsible Party: _____ (Last / First / Middle) Title: Mr./Mrs./Other: _____ Suffix: Jr./Sr./Other: _____

(Employer Info if work related)

Mailing Address: _____ Zip _____ City _____ State _____

Home #: _____ Work #: _____ Ext: _____ Cell #: _____ Other: _____

Email: _____ Date of Birth: _____ Social Security #: _____

Sex: ☐ Male ☐ Female Relationship to Patient: Preferred Language: ☐ English ☐ Spanish ☐ Other:

Current Employer: _____

Employment Status: Fulltime Self Employed Part Time Not Employed Unknown Retired Military Active (circle one)

INSURANCE INFORMATION

Scan/Copy Card

PRIMARY: _____

Relationship to Insured: Self Child Mate Other (circle one)

Insured: Patient Resp Party Other (circle one)

Insured Name: _____

Social Security #: _____ DOB: _____

Group #: _____ Policy#: _____

Eff Date: _____ Exp Date: _____

Contact: _____

Phone: _____

PCP (Name/Phone): _____

SECONDARY: _____

Relationship to Insured: Self Child Mate Other (circle one)

Insured: Patient Resp Party Other (circle one)

Insured Name: _____

Social Security #: _____ DOB: _____

Group #: _____ Policy#: _____

Eff Date: _____ Exp Date: _____

Contact: _____

Phone: _____

PCP (Name/Phone): _____

By signing this, I hereby acknowledge Pontchartrain Orthopedics & Sports Medicine (PRACTICE) has the right to use and disclose protected health information (PHI) for treatment, payment and health care operations, and that I have received the *Notice of Privacy Practices for Protected Health Information (NOPP)*. I understand I have the right to restrict how my PHI is used or disclosed, and that the PRACTICE is not required to agree to any restriction, but if an agreement is reached, the PRACTICE is bound by the agreement.

Signature _____ Patient/Responsible Party (circle one) Date _____

I hereby authorize Pontchartrain Orthopedics & Sports Medicine to evaluate and recommend any testing and/or additional treatment. Initial_____ Date _____

I understand I have the right to refuse any such recommendations/treatment. Initial_____ Date _____

I understand that charges **not covered** by Medicare, Medicaid or Managed Care will be the patient's responsibility. I verify all above information is true and accurate as of the below indicated date. I hereby authorize the attached insurance companies to pay directly to Pontchartrain Orthopedics & Sports Medicine benefits due on my behalf, if any, as provided in the above unexpired policy. I will pay all charges in excess of whatever sums may be allowed by my insurance.

Signature _____ Patient/Responsible Party (circle one) Date _____

Name:
DOB:
Chart:
Age:
Date:

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Pontchartrain
ORTHOPEDICS & SPORTS MEDICINE

GEORGE N. BYRAM, JR., M.D. – RETIRED
JOHN V. GAROUTTE, M.D. – RETIRED

ROBERT MARKS, RN, MBA, CPC
Practice Administrator

(Please Print)

Patient Name _____ Date _____

Age _____ Sex _____ Occupation _____
Dominant Hand ☐ R ☐ L Height _____ Weight _____
Who is your Primary Care Physician? _____
Who referred you here? _____ ☐ Doctor ☐ Family/Friend ☐ Self ☐ Attorney ☐ Other

1. What is your chief complaint (main reason for visit)?
   ☐ Pain ☐ Stiffness ☐ Unstable/Dislocating Joint
   ☐ Numbness ☐ Swelling ☐ Other _____
   ☐ Weakness ☐ Fracture/Broken Bone

2a. Location: What **body part** is involved? _____
b. Left or Right? _____

3. Duration: How long has this problem been present? _____

4. How did the problem start? ☐ gradual ☐ sudden
   (Please select one of the following.)

   A. No injury
      Why do you think the problem started? _____
   B. Injury at work (Date_____)
      From a ☐ lift ☐ twist ☐ bend ☐ pull ☐ reach ☐ other _____
   C. Work related
      How did your job cause this problem? _____
   D. Sports injury (Date_____) What sport? _____
      Please explain _____
   E. Auto accident (Date_____)
      Please describe the accident _____
      ☐ driver ☐ passenger • seatbelt ☐ yes ☐ no • airbag? ☐ yes ☐ no
   F. Other (e.g. fall, direct blow, etc.)
      Please explain _____

5. What is the level of pain? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Name:
DOB:
Chart:
Age:
Date:

6. Please describe the quality of pain. ☐ sharp ☐ dull ☐ throbbing ☐ aching ☐ burning ☐ other _____

7. Since this problem started, it is: ☐ improving ☐ worsening ☐ unchanged

8. Does your pain awaken you from sleep? ☐ yes ☐ no

9. Is your pain: ☐ constant ☐ intermittent (comes and goes)

10. Do you have: ☐ swelling ☐ bruising ☐ numbness ☐ tingling ☐ weakness ☐ bladder or bowel dysfunction ☐ giving out ☐ stiffness ☐ locking ☐ popping/clicking

11. What worsens the problem? ☐ nothing ☐ standing ☐ walking ☐ running ☐ stairs ☐ exercise ☐ squatting ☐ kneeling ☐ lifting ☐ twisting ☐ bending ☐ lying in bed ☐ sitting ☐ coughing ☐ sneezing ☐ throwing ☐ overhead activity ☐ grabbing ☐ repetitive motion (explain, _____) ☐ other _____

12. What helps the problem? ☐ rest ☐ heat ☐ ice ☐ elevation ☐ brace/splint ☐ medicine ☐ nothing ☐ other _____

13. Please list medications taken specifically for this problem. _____

14. Have you had this same problem previously? ☐ no ☐ yes When? _____

15. What previous treatment has been tried? (please provide any detail and dates)
- ☐ none
- ☐ bracing
- ☐ physical therapy _____
- ☐ surgery _____
- ☐ chiropractic _____
- ☐ injection _____
- ☐ previous medicine _____
- ☐ crutches
- ☐ cane
- ☐ other _____

16. Were you seen in the ER or after hour clinic for this problem?
☐ no ☐ yes Where _____ Date _____

17. What tests have you had for this problem?
☐ none ☐ Xray ☐ MRI ☐ CT scan ☐ nerve test (EMG/NCV) ☐ bone scan ☐ ultrasound ☐ other _____

Office use only

_____ f/u	_____ DME	_____ PT	_____ MRI/CT	_____ work stat
_____ med	_____ cast/splint	_____ HEP	_____ Surg	_____ c/s
_____ inj	_____ ice	_____ EMG/NCS	_____ other	

Name:
DOB:
Chart:
Age:
Date:

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(Please Print)

Patient Name _____

Past Medical History (please check all that apply)

	Illness/Injury		Illness/Injury
	High blood pressure		Asthma
	Diabetes		Lung disease (please specify _____)
	Heart attack		Kidney disease (please specify _____)
	Heart problems (please specify _____)		Liver disease (please specify _____)
	Ulcers, stomach or intestinal		Previous anesthesia problems
	Stroke (when _____)		Thyroid problems
	Cancer (please specify _____)		Blood clots/DVT's
	Hepatitis		Bleeding tendency
	HIV/AIDS		Osteoporosis
	Arthritis		Females: Are you or could you be pregnant
	Rheumatologic disease		
	Gout		Other: _____

Past Surgical History (please list previous surgeries)

	Date	Type of Operation	Complication/problems
1			
2			
3			
4			
5			
6			
7			
8			

Please list any current medications

Drug	Dosage and frequency	Drug	Dosage and frequency
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

Do you take blood thinners? ☐ yes ☐ no

Do you have any drug allergies? ☐ yes ☐ no

If yes, please list.

Drug	Reaction	Drug	Reaction
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Please list any other allergies (e.g. egg, iodine, latex). _____

Name:
DOB:
Chart:
Age:
Date:

Social History

Do you use tobacco?	☐ no	☐ yes, # of packs/day ____ # of years ____
Did you use tobacco?	☐ no	☐ yes, when did you quit? _____
Do you drink alcoholic beverages?	☐ no	☐ yes, what type and how often? _____
Are you: ☐ single ☐ married ☐ divorced ☐ widowed		

Family History **(please list any family problems that apply)**

	Illness/Injury		Illness/Injury
	Heart Disease		Rheumatoid arthritis
	Diabetes		Gout
	High blood pressure		Degenerative disorder
	Cancer (please specify _____)		Immunologic disorder
	Anesthesia problems		Other: _____

Review Of Systems **(please check any recent problems)**

	Constitutional symptoms		**Gastrointestinal**		**Neurological**
	Recent weight change		Loss of appetite		Frequent Headaches
	Fever		Nausea or vomiting		Light headed or dizzy
	Unexplained sweating		Frequent diarrhea		Seizures
	Eyes		Constipation		Numbness or tingling
	Wear glasses or contacts		Blood in stool or rectal bleeding		Tremors
	Blurry or double vision		Black tarry stools		Paralysis
	Glaucoma		Abdominal pain or heartburn		**Psychiatric**
	Ear, Nose, Throat		**Genitourinary**		Memory loss or confusion
	Hearing Loss		Frequent urination		Anxiety
	Regular nose or gum bleeding		Burning or painful urination		Insomnia
	Sore throat		Blood in urine		Depression
	Swollen glands in the neck		Incontinence or dribbling		**Endocrine**
	Cardiovascular		Female: _____ # of pregnancies		Glandular or hormone problem
	Irregular heart beats		Female: _____ # of miscarriages		Excessive thirst or urination
	Shortness of breath		**Musculoskeletal**		Heat or cold intolerance
	Chest pain		Joint pain		Changes in hair or nails
	Swelling in the feet, ankles, or hands		Joint stiffness and swelling		**Hematology**
	Fainting spells		Morning stiffness		Bleeding or bruising tendency
	Respiratory		Difficulty walking		Anemia
	Chronic or frequent coughing		Muscle cramping		History of blood transfusion
	Spitting up blood		**Integumentary**		
	Emphysema		Rash or itching		Height _____
	Wheezing		Changes in skin color		Weight _____
			Varicose veins		

Patient Signature (or parent/guardian if patient is a minor) _____ Date _____

Doctor:

I certify that I have reviewed the information on this form.

Doctor Signature	Date	Doctor Signature	Date	Doctor Signature	Date

Name:
DOB:
Chart:
Age:
Date:

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, individually or on behalf of the patient, hereby acknowledge and agree that I have received a copy of Pontchartrain Bone & Joint Clinic's Notice of Privacy Information Practices.

I agree that Pontchartrain Bone & Joint Clinic may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

Signature

Patient's legal representative
(If applicable)

Date

Official use only

Ponchartrain Bone & Joint Clinic has made good faith efforts to attain the above referenced acknowledgement of receipt of the Notice of Privacy Information Practices but is unable to obtain the acknowledgement of receipt. The reason(s) are as follows:

PERMISSION TO DISCLOSE RELEVANT HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN MY HEALTH CARE

☐ I GIVE PERMISSION for Pontchartrain Bone & Joint Clinic to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below who are involved in my health care.

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Name:
DOB:
Chart:
Age:
Date:

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RECORDS RELEASE

DATE _____

TO _____

I HEREBY AUTHORIZE YOU TO RELEASE TO

_____

_____

ANY INFORMATION INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD FROM _____ TO _____

_____
SIGNATURE

_____
PRINT NAME

_____
WITNESS

Name:
DOB:
Chart:
Age:
Date:

Disclosure Form

Please be aware that some of the Pontchartain Orthopedic and Sports Medicine physicians are investors in the following companies:

Jefferson Ambulatory Surgery Center
East Jefferson Ambulatory Surgery Center
Old Gretna Pharmacy
Apothecary Arts Pharmacy
Quantum Labortories

Signature

Date