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

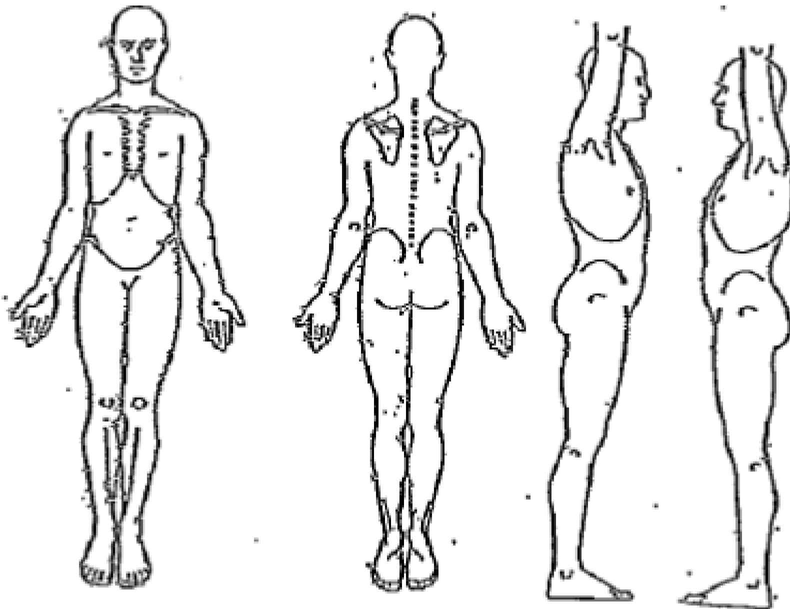
Neck and Back Pain

PCP ______________________ Referred by ______________________

Occupation ______________________

1. What hurts ______________________
2. Is your pain: Mild Moderate Severe
3. What is the level of pain? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
4. What hurts most Neck or Arms

   Back or Legs
5. How long have you been dealing with this issue? ______________________
6. How frequent is this pain? ______________________
7. Please draw where is your pain:



Please circle all that describes the pain:

NUMBNESS
WEAKNESS
SHOOTING
BURNING
TENDER
TWISTING

8. Describe your pain (choose one)
   a. Dull, achy, pressure

      or
   b. Sharp, shooting, electric shock, numbness or tingling

Name:
DOB:
Chart:
Age:
Date:

---

9. Do you have any of the following:
   - Weakness in arms or legs
   - Bowel or bladder Loss of function
   - Fever
   - Problems with coordination and balance

10. Any events that lead to condition? ____________________

____

11. What activities makes this pain worst? ____________________

12. What activities makes this pain better? ____________________

13. **ONLY** For low back and leg pain:

    Do you have:
    - Pain with Mopping/sweeping
    - Pain with Standing in one spot
    - Pain with Walking
    - Stiffness in the morning
    - Numbness or tingling

14. Is this a legal case? If so, any history prior to most recent injury of neck, back or extremity pain? Have you ever seen a doctor, chiropractor, or physical therapist in the past for neck, arm or extremity pain?

____

____

15. What doctors, physical therapist, or chiropractors have you seen up to now for your condition? How long have you been treated by them?

____

____

16. What medications have you tried up to now for this condition?

____________________ ____________________

` ____________________ ____________________

17. Any prior MRI or X-rays? Where were they taken?

____

____

Name:
DOB:
Chart:
Age:
Date:

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Practice Administrator

(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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Practice Administrator

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: ____________________

3939 HOUMA BOULEVARD • DOCTORS ROW #21 • METAIRIE, LOUISIANA 70006 • (504) 885-6464 • FAX (504) 885-8993
105 PLANTATION ROAD • DESTREHAN, LOUISIANA 70047 • (985) 764-3001 • FAX (985) 764-6807
14041 HWY 90 • BOUTTE, LOUISIANA 70039 • (985) 764-3001

Name:
DOB:
Chart:
Age:
Date:

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Practice Administrator

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

3939 HOUMA BOULEVARD ● DOCTORS ROW #21 ● METAIRIE, LOUISIANA 70006 ● (504) 885-6464 ● FAX (504) 885-8993
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Agreement for Use of Controlled Substances

The long-term use of narcotic pain medicine is somewhat controversial as there is a risk of developing a dependency and abusing these medicines. The purpose of this agreement is to protect your access to controlled substances and to protect our ability to give them to you. The use of these medications is governed by the U.S. Drug Enforcement Agency (DEA), the Louisiana Department of Public Safety (OPS) and the Louisiana State Board of Medical Examiners (LSBME). Because these drugs have a high potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies must be agreed upon by you, the patient, before you can receive continued prescriptions to treat your chronic pain. You will receive a copy of these policies and you will need to familiarize yourself and comply with them.

Please initial each blank (required) and Sign the following agreement:

1. _______ All narcotic medications must always come from only one physician, or, during his absence, by the covering physician. It is inappropriate for multiple physicians to be prescribing pain medications at the same time. If you receive a prescription for a controlled substance from another physician, you must notify us at your next office visit. You must inform all other doctors involved in your care that you are receiving controlled substances from our office.
2. _______ Narcotic medications must all be attained from the same pharmacy. Filling prescriptions at multiple pharmacies is not acceptable. The prescribing physician is authorized to discuss all diagnostic and treatment details with the pharmacist at the dispensing pharmacy. If circumstances exist that require you to obtain prescriptions from multiple pharmacies, you must notify us regarding each pharmacy you are using
3. _______ You may not share, sell, or otherwise permit others to have access to any controlled substance prescribed to you.
4. _______ Refills are allowed during office visits only. No refills are given over the phone and on weekends. It is your responsibility to schedule your office visits to allow enough time to get your prescriptions refilled. Under Louisiana law, schedule II prescriptions are only valid for 7 days after they are written and I understand I must get them filled within those 7 days or the prescription is void.

5 _______ Urine drug screens will be required at every visit (monthly) as part of the monitoring process. The presence of any illegal drug (cocaine, marijuana, heroin, amphetamines, designer drugs, etc.) will be considered a violation of this agreement and is grounds for termination of prescription treatment. Refusal to participate in a screen will be considered a positive result. Drug screens may be required at any time, and I can be called in at any time for a random screen.

6. _______ Medications will not be replaced if they are lost, misplaced, or for any other reason. It is your responsibility to safeguard your prescriptions and medications. We highly suggest you fill your prescriptions immediately and keep them in a secure place carrying only a few doses with you at a time. If medications are stolen, a police report must be filled out in order to get refills. Otherwise, early refills will not be given. If one month's medication is utilized in three weeks, the last week will have to be endured with no medication. The patient must contact their physician prior to an increase use of medication.
7. _______ If you have problems with any prescription or medication you receive you MUST bring the prescription or medication to your office visit in order to receive a replacement or change of medication.

Initial each blank and sign.

Name:
DOB:
Chart:
Age:
Date:

---

8. _______ If it appears that narcotic medications are being used inappropriately and against medical advice, then the responsible legal authorities will be notified. All confidentiality is waived and consent is given by the patient to provide the appropriate authorities with full access to the patient's record.
9. _______ To be able to continue to prescribe medication, the physician must have evidence of the patient's participation in any additional prescribed treatment modalities (i.e. physical therapy, exercise program, non-narcotic medication, etc.)
10. _____ Under no circumstances may you alter your prescriptions, attempt to call in unauthorized refills, attempt to obtain medications under a different name, or otherwise use fraud or forgery to obtain controlled substances.
11. _____ Prescriptions may be issued early if the patient or physician will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist not to fill the prescription prior to the appropriate date.
12. _____ All medications must be taken in their intact form. You may not crush, snort, smoke, inject, etc. or otherwise alter any medication you are given.
13. _____ You must not obtain controlled substances from nonphysician sources including but not limited to the internet, friends, or acquaintances, family, out of country mail order sources, sources on the "street" etc.
14. _____ A "Consent to Treat", "Agreement for Use of Controlled Substances," and medical records release are required from the patient in order for your physician to provide controlled substances on a long term basis.
15. _____ You agree to inform your physician of all controlled substances you are taking at each office visit.
16. _____ I understand and agree to the terms and conditions of this agreement. I understand this agreement does not constitute a contract, it only explains our policies of prolonged controlled substance usage. I understand that if I violate this agreement, I will not be able to receive further prescriptions from my pain management physician for controlled substances. If this occurs, I understand that inappropriate or unruly behavior toward my physician or office staff will not be allowed and may result in my being discharged from the practice. I understand that physical dependence on controlled substances can develop and if I am no longer able to obtain medication I may experience withdrawal symptoms that can be severe, even resulting in EMERGENCY DEPARTMENT EVALUATION AND TREATMENT. I understand that if this occurs, it is because of my violation of this agreement and subsequent termination of further controlled substance prescriptions. I hereby understand and agree to the policies detailed in this agreement. I certify I have received a copy of this agreement for my records.

Patient Signature ______________________________ Date ____________ Time __________

Physician Signature ______________________________ Date ____________ Time __________

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