ORTHOPEDIC URGENT CARE

PATIENT INFORMATION

PATIENT NAME Last First M.I.

Social Security Number

ADDRESS Street

DATE OF BIRTH

SEX Female Male

City State Zip

Home Phone

Cell Phone

Work Phone

EMAIL

Marital Status ☐ Single ☐ Widowed ☐ Divorced ☐ Married

PREFERRED METHOD OF CONTACT ☐ Home Phone ☐ Cell Phone ☐ Work Phone

RACE ☐ African American ☐ Asian ☐ Hispanic ☐ Caucasian ☐ Native American ☐ Other

ETHNICITY ☐ Hispanic ☐ Non-Hispanic

EMPLOYER

PATIENTS OCCUPATION

PHARMACY NAME

PHARMACY PHONE

HOW DID YOU HEAR ABOUT US ☐ Community Event ☐ OUC Patient/Friend/Family ☐ Employer ☐ High School/Sport ☐ Hospital/Urgent Care ☐ Insurance ☐ Magazine or Newspaper ☐ Physician ☐ Radio or Television ☐ Website or Online

PERSON RESPONSIBLE FOR CHARGES

NAME

SOCIAL SECURITY NUMBER

ADDRESS Street

DATE OF BIRTH

City State Zip

CONTACT PHONE NO.

EMPLOYER

EMPLOYER PHONE NO.

If this is a job related injury, is this the employer you were working for at the time of injury? ☐ Yes ☐ No

If due to an injury, date of loss: _____/_____/_____

Will an attorney or Liability Carrier be involved in payment of charges? ☐ Yes ☐ No If yes, please explain: _____

Is injury related to: ☐ Accident ☐ Job Related ☐ Other: _____

If job related: Claim # _____ Case Manager: _____ Phone No. _____

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN

NAME OF REFERRING PHYSICIAN

EMERGENCY INFORMATION

IN CASE OF EMERGENCY NOTIFY NAME

RELATIONSHIP

PHONE NO.

ADDRESS Street City State Zip

INSURANCE INFORMATION

PRIMARY

Insured Name: _____
Insured DOB: _____
Insurance Name: _____
Policy ID #: _____
Group/Account #: _____
Social Security #: _____
Relation to Patient:

SECONDARY

Insured Name: _____
Insured DOB: _____
Insurance Name: _____
Policy ID #: _____
Group/Account #: _____
Social Security #: _____
Relation to Patient:

I hereby certify the above information is true and correct to the best of my knowledge. I understand that while OUC contracts with many insurance companies, it is my responsibility to verify with my plan that OUC is a participating provider. It is also my responsibility to find out what my coverage op ons are with my insurance plan. I hereby authorize OUC to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of my insurance coverage.
I acknowledge that photo IDs taken are used to assist in patient recognition per HIPPA guideline.

Patient Signature: _____ Date: _____

Revised: 7/2017

ORTHOPEDIC URGENT CARE

Privacy and Disclosure Statement

Your treatment, payment, enrollment or eligibility for benefits at Orthopedic Urgent Care ("OUC") is not dependent upon whether you sign this Privacy and Disclosure statement. You have the right to revoke this Privacy and Disclosure Statement at any t me by sending a written notice of revocation on LOS at 108 Rue Louis XIV, Lafayette, LA 70508, Attn: Privacy Officer. Our Practice Manager and front office staff will be glad to discuss these acknowledgments and authorizations with you.

By signing below, I acknowledge that I have received the Notice of Privacy Practices of OUC, which explains its legal duties and privacy practices with respect to my protected health information. I understand that if I have indicated my preferred method of contact is by cell phone, I may receive text message communications regarding my scheduled appointments, appointment reminders and missed appointment notifications. I understand that standard message and data rates may apply.

I understand if I choose to opt-out of receiving text message reminders, I am responsible of changing my preferred method of contact with OUC.

I hereby agree that OUC may disclose any and all of my protected health information to the following individuals, all of whom are involved in my care for any purpose related to my treatment or the payment of my care.

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Signature of Patient/Patient's Representative: _____ Date:_____

Printed Name of Patient/Patient's Representative: _____

Revised: 7/2017

ORTHOPEDIC URGENT CARE

Financial Policy

Orthopedic Urgent Care ("OUC") places its patients' needs first; however, we must be financially responsible to continue to serve.

- I understand that it is my responsibility to know my insurance benefits and plan coverage. My insurance may or may not cover the services provided at OUC. To obtain the most accurate information, please check with your insurance carrier to discuss the benefits provided by your medical plan prior to your visit to fully understand your anticipated out of pocket costs.
- I understand that co-payments, deductibles, co-insurance and non-covered services are to be paid at or before the time of service. OUC accepts cash, checks, major credit cards, debit cards, HSA/FSA and Care Credit. You may also pay your bill online from the Patient/Bill Payment section of our website.
- I understand that I may be contacted by the telephone regarding my outstanding balance with OUC.
- I understand that if I do not have my insurance and, referral, and/or co-payment, that my appointment may be rescheduled until such time that I can provide the required documents or payments.
- I understand that OUC will collect, prior to any surgery or procedure, deductibles and coinsurance up to an amount equal to payment in full for the planned surgical procedure. Surgeries will include Physician Assist fees that will be billed a ter your surgery. Payment in full and expected coinsurance payment responsibility are determined by the anticipated surgical billing code(s), details of your insurance policy, and agreement between your insurance company and OUC. If the full deductible is not applied to your claim by your insurance company, OUC will refund any overpayment to you when we receive overpayment.
- I understand if my account has a patient responsibility amount that is not paid in full within 90 days then my account may be placed with an outside collection agency. No additional appointments will be made for delinquent accounts until they are brought current unless the appointment is of an urgent nature.
- I understand that a $35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. Non-Sufficient Fund checks must be redeemed with certified funds (credit card or cash).
- I understand that I have until 5 p.m. the day before my appointment to cancel or reschedule. If I do not show up for my appointment and did not cancel in time, a $40 no-show fee will be charged to my account.
- I understand that there may be fees associated with medical records requests and completion of forms by a physician. I understand that I may be responsible for these fees.

Statement of Financial Responsibility: I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my insurance plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO), or any other payer. I have read and I understand the above Financial Policy and I agree to abide by its terms.

Patient or Guarantor Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

NEW PATIENT MEDICAL HISTORY

Patient Name: _____	**Height:** _____	**Weight:** _____
Race: ○ African American ○ Asian ○ Caucasian ○ Native American/Alaskan ○ Pacific Islander ○ Other ○ Unknown ○ Decline to Answer		
Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Unknown ○ Decline to Answer		
Preferred Language: ○ English ○ Spanish ○ Chinese ○ Other: _____		
Preferred Pharmacy: _____		
Referral Source (Doctor Name): _____	**Other (ex: Google)**:_____	

Chief Complaint

Dominant Hand: ○ Right ○ Left ○ Ambidextrous

Description of Symptoms: (select only ONE primary symptom and ONE affected area)

○ Pain ○ Numbness/Tingling ○ Fracture ○ Stiffness ○ Other: _____

Shoulder	○ Right	○ Left	Pelvis	○ Right	○ Left	Neck ○
Upper Arm	○ Right	○ Left	Hip	○ Right	○ Left	Upper Back ○
Elbow	○ Right	○ Left	Thigh	○ Right	○ Left	Mid Back ○
Forearm	○ Right	○ Left	Knee	○ Right	○ Left	Low Back ○
Wrist	○ Right	○ Left	Lower Leg	○ Right	○ Left	Buttocks ○
Hand	○ Right	○ Left	Ankle	○ Right	○ Left	Tail Bone ○
Thumb	○ Right	○ Left	Foot	○ Right	○ Left	
Index	○ Right	○ Left	Great Toe	○ Right	○ Left	
Middle	○ Right	○ Left	2nd Digit	○ Right	○ Left	
Ring	○ Right	○ Left	3rd Digit	○ Right	○ Left	
Little	○ Right	○ Left	4th Digit	○ Right	○ Left	
			5th Digit	○ Right	○ Left	

Pain radiates from/to (ex: low back to right leg) _____

History of Present Illness

1. Is your problem the result of an injury of accident?

○ No Injury ○ Injury ○ Injury at Work ○ Auto Accident ○ Sport Injury ○ Prior Surgery

How long have the symptoms been present? (ex: 2 months): _____

Describe the onset: ○ Acute (sudden) ○ Chronic condition (>3 months)

Onset Date: (mm/dd/yyyy) _____

2. Are you represented by an attorney? ○ Yes ○ No

Attorney Name: _____

Will there be any legal actions with respect to this problem? ○ Yes ○ No

3. Have you had a problem like this before? ○ Yes ○ No

Describe:

_____

_____

4. **Have you been seen in an ER for this Problem?** ○ Yes ○ No

Treating ER: _____ Date (mm/dd/yyyy): _____

5. Rate the pain (10 being the most pain):

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

6. Do the symptoms wake you from sleep? ○ Yes ○ No

7. Please describe the symptoms:

○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning ○ Shooting

History Present Illness (continued)

8. What is the timing of the symptoms?

○ Constant ○ Intermittent (comes and goes)

9. Is the problem getting better or worse?

○ Getting better ○ Getting worse ○ Unchanged

10. What makes the symptoms worse?

○ Squatting ○ Kneeling ○ Sitting ○ Bending ○ Stairs ○ Twisting ○ Moving ○ Lying in bed
○ Running ○ Walking ○ Athletics ○ Standing ○ Gripping ○ Lifting ○ Reaching overhead

11. Are there any symptoms associated with this problem?

○ Redness ○ Bruising ○ Swelling ○ Numbness ○ Stiffness ○ Limping ○ Clicking ○ Locking
○ Popping ○ Tingling ○ Weakness ○ Giving way

Prior Testing/Treatment

Have you had any prior tests for this problem?

○ None ○ X-rays ○ MRI ○ CT Scan ○ Nerve Tests (EMG/NCV) ○ Bone Scan

Have you had any prior treatment for this problem? ○ Yes ○ No

Type of Treatment	**Status of Symptoms after treatment (select only those that apply)**			**Date of Treatment**
Ice	○ Improved	○ Worsened	○ Unchanged	_____
Heat	○ Improved	○ Worsened	○ Unchanged	_____
Rest	○ Improved	○ Worsened	○ Unchanged	_____
NSAIDs	○ Improved	○ Worsened	○ Unchanged	_____
Muscle Relaxers	○ Improved	○ Worsened	○ Unchanged	_____
Chiropractor	○ Improved	○ Worsened	○ Unchanged	_____
Physical Therapy	○ Improved	○ Worsened	○ Unchanged	_____
Home Exercise Prog.	○ Improved	○ Worsened	○ Unchanged	_____
Surgery	○ Improved	○ Worsened	○ Unchanged	_____
Injections	○ Improved	○ Worsened	○ Unchanged	_____
Bracing	○ Improved	○ Worsened	○ Unchanged	_____
TENS unit	○ Improved	○ Worsened	○ Unchanged	_____
Other/Comments:_____				

Previous Hospitalizations/Surgeries: ○ None

○ Aneurysm (Brain) Surgery	○ Hysterectomy	Orthopedic on side:	Right	Left
○ Aortic Bypass/Vascular Surgery	○ LAP Band/Gastric Bypass Surgery	Arthroscopy: Knee	○	○
○ Appendectomy	○ Lumpectomy	Arthroscopy: Shoulder	○	○
○ Cataract (Eye) Surgery	○ Mastectomy	Carpal Tunnel Release	○	○
○ Cholecystectomy (Gallbladder)	○ Malignancy/Cancer	Rotator Cuff Repair	○	○
○ Heart Surgery	○ Stents	Total Hip Replacement	○	○
○ Hernia Repair		Total Knee Replacement	○	○
Other Surgery:_____		Total Shoulder Replacement	○	○
_____		Spinal Surgery Level: _____		

Medical Questions

Mark all that currently apply:

○ Metal in Body ○ Claustrophobic ○ Pregnant ○ Sleep Apnea ○ Uses a CPAP ○ Snores

Are you taking blood thinners? ○ Yes ○ No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months: ○ None for all

				NONE	Comments:
CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue	○	_____
EYE	○ Blurred vision	○ Double Vision	○ Vision Loss	○	_____
ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing	○	_____
CV	○ Chest Pain	○ Palpitations		○	_____
RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath	○	_____
GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool	○	_____
GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems	○	_____
SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps ○ Psoriasis	○	_____
NEU	○ Frequent Falls	○ Loss of Coordination	○ Numbness	○	_____
PSY	○ Change in Bowel	○ Change in Bladder	○ Dizziness	○	_____
ENDO	○ Depression/Anxiety	○ Drug/Alcohol Addiction	○ Sleep Disorder	○	_____
HEM	○ Fever	○ Heat/Cold Intolerance	○ Night Sweats	○	_____
	○ Easy Bleeding	○ Easy Bruising	○ Anemia	○	_____

Family History

Have any direct relatives had any of the following disorders? ○ None for all

Father	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments: _____			
Mother	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments: _____			
Sibling	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments: _____			

Social History

Do you smoke? ○ Current, every day smoker ○ Current, some day smoker ○ Former Smoker ○ Never ○ Heavy tobacco smoker ○ Light tobacco smoker

Do you drink alcohol? ○ Daily ○ Occasionally ○ Rarely ○ Never

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Domestic Partnership

Are you currently working? ○ Yes ○ No ○ Retired ○ Disabled If no, what date did you last work? _____

Please list work restrictions, if any:

_____

Occupation: _____ **Employer:** _____ ○ **Student**

Allergies

Do you have any allergies? ○ Yes ○ No If Yes, please list below:

Medication, Relevant Food, or "Seasonal"	Reaction

Latex allergy? ○ Yes ○ No

Medications

Please list all medications you take on a regular basis: ○ None

Medications	Dosage and Frequency (e.g. 20 mg, once/day)

Medical Conditions

Do you have a personal history of any of the following? ○ None

○ Aneurysm Where: _____	○ Emphysema	○ Kidney Disease
○ Angina (Chest Pain)	○ Epilepsy	○ Kidney Stones
○ Arthritis Type: _____	○ Heart Attack	○ MRSA Infection
○ Asthma	○ Hepatitis Type: _____	○ Pacemaker
○ Bone or Joint Infections	○ HIV/AIDS	○ Phlebitis (Blood Clots)
○ Cancer Type: _____	○ High Cholesterol	○ Pulmonary Embolism
○ Chemotherapy/Radiation	○ Hypertension	○ Reaction to Anesthesia Type: _____
○ COPD	○ Hyperthyroidism	○ Seizures
○ Congestive Heart Failure	○ Hypothyroidism	○ Stomach Ulcers
○ Diabetes Type _____	Last A1C: _____	○ Stroke/TIA
		○ Tuberculosis

Please list any other conditions or details of conditions marked above: _____

_____

_____

Signature:_____ **Date:** _____