LARRY S. BANKSTON, JR., M.D.

BOARD CERTIFIED ORTHOPAEDIC SURGEON

BROC
BATON ROUGE ORTHOPAEDIC CLINIC

Name: _____

Chart: _____

Date: _____

Welcome to the Baton Rouge Orthopaedic Clinic. We are committed to providing the best, most comprehensive orthopaedic care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks, if you need assistance filling out this form please notify the receptionist.

Demographics **Please print all information.**

Patient's Name: (Lastname, Firstname)	Date of Birth:
Gender: (circle one) Male Female	Age:

○ **I DECLINE TO RELEASE THIS INFORMATION AT THIS TIME.**

Race: (circle one) American Indian Asian African-American Native Hawaiian Type-Unknown Caucasian

Ethnicity Choices: (circle one) Hispanic Origin Non-Hispanic Type-Unknown

Preferred Language:	**Email Address:**

Address:		
City:	State:	Zip Code:
Social Security Number:	Drivers license number and state:	
Contact Telephone 1	Contact Telephone 2	Contact Telephone 3
If a minor name of guardian and relationship:	**Employer Name:**	

Notify in Case of Emergency

Name:	Relationship:
Contact Telephone 1	Contact Telephone 2	Contact Telephone 3

Billing Information

Who is Responsible for the bill?

Primary Insurance Company: _____

Name of Insured: _____ Insured Date of Birth: _____

Primary Card Holder's SSN: _____

Secondary Insurance Company: _____

Name of Insured: _____ Insured Date of Birth: _____

Primary Card Holder's SSN: _____

○ **Self Payment** ○ **Responsible Attorney:** (Please Print) _____

Problem Information

Is this injury work related: Yes ○ No ○ If YES, was the injury reported to the employer: Yes ○ No ○

Details of Problem

Part of body to be checked: _____ How long have you had these symptoms: _____

Nature of problem: Other ○ Injury ○ Do you have x-rays: Yes ○ No ○ Date of Injury: _____

How did injury occur: _____

Please list all physicians seen for this problem: _____

Who can we thank for referring you to our clinic? _____

Who is your Primary Care Physician?

I hereby assign my insurance benefits plan for medical services rendered to Baton Rouge Orthopaedic Clinic. I understand that I am financially responsible for any charges not covered by this assignment; payment of all services rendered, regardless of insurance coverage or other third party liability; and pay all costs of collection, including reasonable attorney fees and court costs in the event it becomes necessary to pursue the account for collection. I also hereby authorize the release of information required in the course of my examination as may be needed to process my insurance.

Signature: _____ Date: _____

Name: _____

Chart: _____

Date: _____

Social History

Are you:	○ Single	○ Married	○ Divorced	○ Widowed	○ Other
Living Arrangements:	○ Home alone	○ Home with Spouse	○ Assisted Living	○ Nursing Home	○ Other

Smoking Status: ○ Current every day smoker - If yes, _____ Pack(s)/day _____ Pack(s)/week _____ Number of years smoked

○ Current some day smoker ○ Smoker, current status unknown ○ Never smoked

○ Former smoked ○ Unknown if ever smoked

Do you drink alcohol regularly? ○ Yes ○ No If yes, please list the amount and type ingested per day:_____

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

Illness	Yes	No	Illness	Yes	No
Cancer			Rheumatoid Arthritis		
Heart Attack/Disease			Degenerative Arthritis		
High Blood Pressure			Thyroid Disease		
Diabetes			Immune Disorders		

Review of Systems

	Yes	No		Yes	No		Yes	No
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			Rectal bleeding or blood in stool			Tremors		
Blurred or double vision			Black tarry stools			Paralysis		
Glaucoma			Regular abdominal pain or heartburn			**Psychiatric**		
ENT			**Genitourinary**			Memory loss or confusion		
Hearing loss			Frequent urination			Anxiety		
Regular nose or gum bleeding			Burning or painful urination			Depression		
Sore throat			Blood in urine			Insomnia		
Swollen glands in 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 w/walking or lying flat			**Musculoskeletal**			Heat or cold intolerance		
Swelling in feet, ankles, and hands			Joint pain			Changes in hair or nails		
Fainting spells			Joint stiffness and swelling			**Hematology**		
Elevated cholesterol			Morning stiffness			Bruising tendency		
Respiratory			Difficulty walking			Anemia		
Chronic or frequent coughing			Muscle cramping			Need for past transfusion		
Spitting up blood			**Integumentary**			**Patient: Please provide ht. & wt.**		
Regular shortness of breath			Rash or itching			Height _____		
Emphysema			Changes in skin color			Weight _____		
Regular wheezing			Varicose veins					

Allergies Do you have a history of latex allergy? Yes ○ No ○ Do you have a history of adhesive tape allergy? Yes ○ No ○

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

Past Surgical History

Year	Name of Operation	Type of Anesthetic (general, regional, local)	Complications

Name: _____

Chart: _____

Date: _____

Illness/Injury	Yes	No	Illness/Injury	Yes	No
High Blood Pressure			Kidney disease		
Diabetes			Liver disease		
Heart attack/disease			Females ONLY: Are you or could you be pregnant?		
Chest pain or angina			AIDS or HIV Infection		
Stroke			Thyroid problems		
Cancer			Shortness of breath		
Hepatitis			Blood clots		
Stomach Ulcers			Bleeding tendency		
Arthritis			Pacemaker		
Gout			Accidents / Broken bones (please list)		
Osteoporosis					

Medications

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

Do you take diet pills or nutritional supplements? Yes ○ No ○

If yes, please list the type and when last taken:

Name	Date Last Taken
1.	
2.	

Immunization History When was your last tetanus shot?

Medication History Patient Consent

I agree that Baton Rouge Orthopaedic Clinic may request and use my prescription medication history from other healthcare providers or third-party pharmacy payors for treatment purposes. **Yes** ○ **No** ○

Pharmacy

I wish to use _____ Pharmacy, located at _____

NAME OF PHARMACY *STREET*

_____ telephone number ( ) _____, for

CITY *STATE* *ZIP CODE* *AREA CODE* *TELEPHONE NUMBER*

filling prescriptions for all my medications prescribed by Baton Rouge Orthopaedic Clinic providers.

I certify that to the best of my knowledge the preceding information is true and accurate.

_____ _____

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

Name: _____

Chart: _____

Date: _____

Baton Rouge Orthopaedic Clinic, LLC

When you return this form to the receptionist **please bring your insurance card**. We cannot bill your insurance unless you give us your current, accurate insurance information.

As a courtesy to you we will bill your insurance company for services provided**. All co-payments and unsatisfied deductibles must be paid at time of service;** our office expects payment in full from your insurance within 90 days unless otherwise specified by a contract with your insurance provider. In the event that your insurance makes payment at a later date all overpayments will be refunded to you.

I have read and understand that I am ultimately responsible for all fees regardless of insurance coverage including any legal or other cost incurred in the collection of this account, if it becomes delinquent. I authorize Baton Rouge Orthopaedic clinic to release any medical information necessary to process insurance forms. I further authorize payment of medical benefits to Baton Rouge Orthopaedic Clinic.

Signed: _____ **Date:** _____

Acknowledgement of Receipt of Privacy Notice
Effective April14, 2003

I have been presented with a copy of Baton Rouge Orthopaedic Clinic's **Notice of Privacy policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:

_____

Signed: _____ **Date:** _____

The person listed below has my permission to discuss my medical information:

Printed Name: _____ **DOB:** _____

Last 4 digits of SSN: _____

* This form will expire in one year.