FONDREN ORTHOPEDIC GROUP L.L.P.

Please complete to the best of your ability/ Please Print clearly

Patient Name:_____ Today's Date:_____
Age_____ Are you? Right handed Or Left handed
Referring Doctor:_____ or Referring Friend_____
Describe your problem:_____
Duration of Symptoms:_____ or Date of Injury:_____
Cause of Injury:_____
Describe your pain: constant/burning/stabbing/shooting/sharp/aching/throbbing
What makes your pain worse?_____
What makes your pain better?_____
Please rate your pain: (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)
Studies already performed for this problem? Xrays/ CAT scan/MRI / Nerve study
Treatment so far? None/Anti-inflammatory pills/Physical therapy/Injections
Anti-inflammatories if so what kind_____ How long_____
Will there be any legal action with respect to this problem? Yes / No/ Maybe
Are you represented by an attorney?_____
Review of Systems (Are you experiencing any of the following symptoms?)
Fever / Night Sweats / Loss of appetite / Unintentional weight loss / Change in Bowel or bladder habits / Weakness / Frequent falls / Loss of coordination
Your Own Personal Medical History (check all that apply to you)

__Heart attack	__Stroke/TIA	__Hepatitis__HIV
__Angina (chest pain)	__Seizures	__Cancer____
__Congestive heart failure	__Diabetes	__Bladder infection
__High Blood Pressure	__Phlebitis(blood clot)	__Kidney stones
__Asthma/Emphysema	__Pulmonary embolus	__Stomach Ulcers

__Other_____

List all surgeries you have had:

_____ _____
_____ _____

List all medications that you currently take:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Pharmacy Name:_____ **Phone Number:**_____
List allergies to medications:

_____ _____ _____

Family Medical History (describe conditions that run in your family):

_____ _____ _____

Social History:
Occupation_____If retired, for how long?_____
Employer_____
With whom do you live?_____
Do you smoke? If so, How many packs/day?_____
Do you drink alcohol? If so, how much?_____
Height:_____Feet _____Inches Weight:_____pounds
Do you have any metal in your body? Yes / No Are you claustrophobic Yes/No

NEW PATIENT INFORMATION RECORD

Please Print Clearly

PATIENT INFORMATION		**DATE:**
REASON FOR YOUR VISIT TODAY?		
PATIENT NAME:		
ADDRESS:		
CITY:	STATE:	ZIP:
HOME PHONE: ( )		BUSINESS PHONE: ( )

CELL PHONE ( ) PAGER ( )

DATE OF BIRTH: / /	AGE:	MALE OR FEMALE (please circle one)
SS# - -	MARITAL STATUS	**S / M / W / D / SEP Spouses Name:**
EMPLOYER:	OCCUPATION:	PART TIME / FULL TIME
DRIVERS LICENSE NUMBER:		STATE:
RESPONSIBLE PARTY'S NAME:		ADDRESS:
CITY: STATE: ZIP:		HOME( ) WORK( )

PRIMARY INSURANCE

PRIMARY INSURANCE COMPANY:	SUBSCRIBER ID NO:
(IF BC/BS INS.) PREFIX :	GROUP:
INSURED NAME:	DOB:
INSURED ADDRESS:	INSURED EMPLOYER:
PATIENT RELATIONSHIP TO INSURED:	

SECONDARY INSURANCE

SECONDARY INSURANCE COMPANY:	SUBSCRIBER ID NO:
(IF BC/BS INS.) PREFIX:	GROUP:
INSURED NAME:	DOB:
INSURED ADDRESS:	INSURED EMPLOYER:
PATIENT RELATIONSHIP TO INSURED:	

PLEASE NAME ANY FAMILY MEMBERS THAT HAVE BEEN SEEN BY OUR PHYSICIANS?

(please circle one) RELATIVE, FRIEND, INSURANCE PLAN, EMPLOYER, OR OTHER

REFERRING PERSON'S NAME:
ADDRESS:
TELEPHONE NUMBER: ( )

IN CASE OF EMERGENCY CONTACT (NAME AND PHONE NUMBER):

STEVEN E. NOLAN, M.D.
ARTHUR F. CHAU, M.D.

Date:_____

PLEASE FILL OUT THIS REPORT
PLEASE ESTIMATE DATE OF FIRST SYMPTOMS

Dear Patient:

The following accident details may be required by your insurance company in order to process your claim. Helping us to gather this information prior to our office submitting your claim, will enable us to assist you in getting your insurance company to pay your claim on a timely manner.

Patient:_____ Insured:_____

Insured's I.D. Number:_____ Group/Policy Number_____

1.) Briefly describe **WHERE** and **HOW** the accident/ illness occurred. THIS MUST BE COMPLETED TO GET YOUR CLAIM PAID.

_____

_____

_____

2.) What was the date and time of the accident OR the first date of symptoms? (If you are unsure, please estimate.)

_____

3.) Was the accident / illness work related? _____ Sports related?_____

_____ _____

Patient's Signature or Parent/Guardian
If patient is a minor

Date