OSNO

Orthopaedic Specialist of New Orleans, APMC

Dr. Richard L. Meyer, JR., M.D.
Board Certified Orthopaedic Surgeon
Dr. Scott A. Tucker, M.D.
Board Certified Orthopaedic Sports Medicine

Date: _____

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____ Suffix: _____

Date of Birth: _____ Age: _____ Male Female Married Single Divorced Widowed

Address: _____ City, State, Zip: _____

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

SS# _____ **Email Address:** _____

Primary Care Physician? _____ Who can we thank for referring you?: _____

Patients Employer: _____ Occupation: _____

Address: _____ City, State, Zip: _____

Insurance Information

Primary Insurance Company: _____ Policy Number: _____

Policy Holder Name: _____ Relation to Policy Holder: _____ Policy Holder Birthdate: _____

Secondary Insurance Company: _____ Policy Number: _____

Policy Holder Name: _____ Relation to Policy Holder: _____ Policy Holder Birthdate: _____

Is your visit a result of a **work injury** or **car accident**? YES NO

If so, where did your injury occur? _____ Date of Injury: _____

Are you or do you plan to be represented by an attorney? YES NO

Emergency Contact Information

Emergency Contact Name: _____ Phone #: _____

Relation to Emergency Contact: _____

Emergency Contact Address: _____ City, State, Zip: _____

Attorney Information

Attorney Name: _____

Phone#: _____ Fax #: _____

Workers Compensation

Workers Compensation Claim #: _____ Adjuster: _____

Insurance Name: _____

3434 Prytania St., Suite 310, New Orleans, LA 70115 * Office (504)897-7877 * Fax (504)897-7814

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Pharmacy Information

Pharmacy: _____ Pharmacy Phone#: _____

Pharmacy Address: _____ City, State, Zip: _____

*Medical Information Release Form **(HIPPA release form)**

Name: _____ **DOB:** _____

[ ] I authorize the release of information including diagnosis, records, examination rendered to me and claims information. This information may be released to:

- Spouse- _____
- Child(ren)- _____
- Other- _____

[ ] Information is not to be released to anyone.

This ***Release of information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home _____ [ ] my work _____ or

[ ] my cell _____.

If unable to reach me

- You may leave a detailed messaged on my phone.
- Please leave a message asking me to return your call.
- Other: _____.

The best time to reach me is (day) _____ between (time) _____.

Signed: _____ Date: _____

Printed Name: _____

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Orthopaedic Specialists of New Orleans

Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my healthcare, Orthopaedic Specialists of New Orleans, AMPC originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.

I understand that Orthopaedic Specialists of New Orleans, APMC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that refusing to sign this consent or revoking this consent, this organization may refuse to treat permitted by sec. 164.506 of the Code of Federal Regulations.

I further understand that Orthopaedic Specialists of New Orleans, APMC reserves the right to change their notice and practices and prior to implementation, in accordance with Sec. 164.520 of the Code of Federal Regulations. Should Orthopaedic Specialists of New Orleans, APMC change their notice, they will send a copy of any revised notice to the address provided.

I request the following restrictions to the use or disclosure of my health information:

_____
_____
_____
_____
_____
_____
_____

I understand that as part of this organization's treatment, payment, or healthcare operation it may become necessary to disclose my protected health information to another entity, therefore I, _____, consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

_____Accepted _____ Denied

Signature_____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

For office use only:

Patient Name:_____
File Record #:_____
Date of Intake: _____

By signing this form, you acknowledge that Orthopaedic Specialists of New Orleans has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us. This includes the situation where your first date of service occurred.

I understand the contents of the notice, and request the following restrictions concerning the use of my personal medical information:_____

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

_____
Patient's Name – Please Print

_____
Patient's Signature

For Office Use Only

We have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices. Acknowledgement could not be obtained for the following reason(s):

¨ Patient/Individual refused to sign (Date of refusal)_____

¨ Other _____

Attempt was made by: _____ date: _____

Patient Name: **Date:**

Medical disorders: If you have had any of the following, Place Mark inside Circles

- ○ No Medical History
- ○ AIDS/HIV
- ○ **Alcoholism**
- ○ **Alzheimer's**
- ○ **Anemia**
- ○ **Rheumatoid Arthritis**
- ○ **Asthma**
- ○ **Blood Clot Leg**
- ○ **Blood Clot Lung**
- ○ Stroke
- ○ Cancer Breast
- ○ Cancer **Colon**
- ○ Cancer **Lung**
- ○ Cancer **Prostate**
- ○ **COPD**
- ○ **Depression**
- ○ **Diabetes**
- ○ **Drug Abuse**
- ○ Sleep Apnea
- ○ Gout
- ○ Heart Attack
- ○ High Blood Pressure
- ○ Hepatitis
- ○ Kidney Disease
- ○ Osteoarthritis
- ○ Seizures
- ○ Ulcers, Bleeding

○ **Other Disease** (list below)

○ **Blood thinners (Coumadin, Plavix, aspirin, etc)**

Surgical History: If you have had any of the following, Place Mark inside Circles

- ○ No Surgical History Reported
- ○ Carpal Tunnel Left Wrist
- ○ Arthroscopy Left Elbow
- ○ Arthroscopy Left Shoulder
- ○ Arthroscopy Left Ankle
- ○ Arthroscopy Left Knee
- ○ Arthroscopy Left Hip
- ○ Left Hip Replacement
- ○ Left Knee Replacement
- ○ Spinal Fusion
- ○ Other Surgery (list in the box below)
- ○ Cardiac (Heart)
- ○ Carpal Tunnel Right Wrist
- ○ Arthroscopy Right Elbow
- ○ Arthroscopy Right Shoulder
- ○ Arthroscopy Right Ankle
- ○ Arthroscopy Right Knee
- ○ Arthroscopy Right Hip
- ○ Right Hip Replacement
- ○ Right Knee Replacement
- ○ Laminectomy
- ○ Fracture Surgery

Patient Name. **Date:**

Family History:

If any family Member below has any of the following history. Place Mark inside Circles

Father Medical History

- ○ AIDS/HIV
- ○ Anemia
- ○ Blood Clots
- ○ Cancer
- ○ Coronary Artery Disease
- ○ Diabetes
- ○ Gout
- ○ Heart Attack
- ○ Hemophilia
- ○ Hypertension
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Mother Medical History

- ○ AIDS/HIV
- ○ Anemia
- ○ Blood Clots
- ○ Cancer
- ○ Coronary Artery Disease
- ○ Diabetes
- ○ Gout
- ○ Heart Attack
- ○ Hemophilia
- ○ Hypertension
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Sibling Medical History

- ○ AIDS/HIV
- ○ Anemia
- ○ Blood Clots
- ○ Cancer
- ○ Coronary Artery Disease
- ○ Diabetes
- ○ Gout
- ○ Heart Attack
- ○ Hemophilia
- ○ Hypertension
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Patient Name: **Date:**

Review of Systems: If you have any of the following, Please Place Mark inside Circles

Constitutional
- O Weight Loss/Gain
- O Weakness
- O Fatigue
- O Fever

Cardiovascular
- O High Blood Pressure
- O Chest Pain
- O Rheumatic Fever
- O Palpitations
- O Has Pacemaker

Musculoskeletal
- O Joint Pain
- O Arthritis
- O Muscular Weakness
- O Stiffness
- O Muscular Pain

Eyes
- O Glasses or Contacts
- O Blurred Vision
- O Glaucoma
- O Cataracts
- O Excessive Tearing

Skin
- O Rashes
- O Sores
- O Lumps
- O Dryness
- O Itching

Blood or Lymph
- O Anemia
- O Easy Bruising
- O Easy Bleeding
- O Swollen Glands

Ear Nose Mouth Throat:
- O Ears Ringing
- O Earaches
- O Hearing Aid
- O Frequent Colds
- O Nasal Discharge
- O Hay Fever
- O Nosebleeds
- O Dentures
- O Bleeding Gums
- O Frequent Sore throats

Neurological
- O Headache
- O Dizziness
- O Seizures
- O Loss of Sensation
- O Vertigo

Gastrointestinal
- O Heart Burn
- O Rectal Bleeding
- O Abdominal Pain
- O Gallbladder trouble
- O Hepatitis

Respiratory
- O Shortness of Breath
- O Cough
- O Wheezing
- O Asthma
- O Bronchitis

Genitourinary
- O Blood in Urine
- O Urinary Infections
- O Kidney Stones
- O Burning Urination
- O Sexual Disease

Endocrine
- O Thyroid Trouble
- O Excessive Sweating
- O Excessive thirst

Immunologic
- O Reactions to Drugs
- O Skin Rashes
- O Reactions to Foods

Psychological
- O Nervousness
- O Depression
- O Mood Changes

Patient Name: **Date:**

Social History: Please respond to the following by Placing Mark inside Circles

Substance Use:

Do you:

Use Tobacco?	O Yes	O No	O Former
Use Alcohol?	O Yes	O No	
Use Caffeine?	O Yes	O No	
Use Illicit Drugs?	O Yes	O No	

I do not use any of the above O

Hand Dominance? O Right Handed O Left Handed

Females Only:

Could you be pregnant? O Yes O No

Allergies: Do you have allergies to any of the following medications or substances

O No Known Allergies	O Aspirin	
O Penicillin	O Amoxil	O Tegretol
O Codeines	O Keflex	O Bactrim
O Sulpha Drugs	O Cefzil	O Pediazole
O Iodine / Shellfish	O Ceftin	O Dilantin
O Ampicillin	O Suprax	O Novacaine
O Vantin	O Septra	O Insulin
O Depakene	O Lamictal	O Lidocaine

Other Allergies:

O Latex O IVP/X-Ray Dye O Metal O Egg/Avian (Bird)

List any other allergies in this box