



M&M ORTHOPAEDICS

Extraordinary Outcomes

DATE _____

FOR OFFICE USE ONLY

ACCT# _____

REVIEWED BY _____

Welcome to our office. Please print and complete all entries

PATIENT'S FULL LEGAL NAME (LAST, FIRST, MI)	SEX	DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER
PATIENT'S STREET ADDRESS		HOME PHONE NUMBER ()		OCCUPATION
CITY, STATE, ZIP CODE		WORK PHONE NUMBER ()		CELLULAR PHONE NUMBER ()
IF THE PATIENT IS A MINOR, WHO BROUGHT THEM TO THE APPOINTMENT? RELATIONSHIP:		EMAIL ADDRESS (IF THE PATIENT IS A MINOR, PLEASE INCLUDE GUARDIAN'S EMAIL ADDRESS)		

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE NUMBER ()
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PRIMARY INSURANCE POLICY HOLDER'S INFORMATION

NAME OF SUBSCRIBER (POLICY HOLDER)	SEX	DATE OF BIRTH	PATIENT RELATIONSHIP TO INSURED: <input type="radio"/> SPOUSE <input type="radio"/> FOSTER CHILD/GUARDIAN <input type="radio"/> CHILD
POLICY HOLDER'S STREET ADDRESS			HOME PHONE NUMBER ()
CITY, STATE, ZIP CODE			SOCIAL SECURITY NUMBER

SECONDARY INSURANCE POLICY HOLDER'S INFORMATION

NAME OF SUBSCRIBER (POLICY HOLDER)	SEX	DATE OF BIRTH	PATIENT RELATIONSHIP TO INSURED: <input type="radio"/> SPOUSE <input type="radio"/> FOSTER CHILD/GUARDIAN <input type="radio"/> CHILD
POLICY HOLDER'S STREET ADDRESS			HOME PHONE NUMBER ()
CITY, STATE, ZIP CODE			SOCIAL SECURITY NUMBER

PRIMARY CARE PHYSICIAN, FAMILY PHYSICIAN, or PEDIATRICIAN

NAME OF PRIMARY CARE PHYSICIAN YOU LAST HAD AN APPOINTMENT WITH	PHONE NUMBER ()
CITY, STATE, ZIP CODE	

RACE

ASIAN NATIVE HAWAIIAN OR OTHER PACIFIC BLACK/AFRICAN AMERICAN WHITE HISPANIC OTHER RACE OTHER PACIFIC ISLANDER

ETHNICITY

HISPANIC OR LATINO NOT HISPANIC OR LATINO

LANGUAGE

ENGLISH OTHER INDIAN (INCLUDES HINDI & TAMIL) SPANISH RUSSIAN



M&M ORTHOPAEDICS

PATIENT'S NAME _____

ACCOUNT NUMBER _____

Extraordinary Outcomes

I. CONSENT FOR DIAGNOSIS AND TREATMENT

I am visiting M&M Orthopaedics, Ltd. voluntarily for the purpose of diagnosis and medical or surgical treatment. I consent to consultation by my physician, physician assistant or therapist, and x-rays as deemed necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of treatment or examination while visiting M&M Orthopaedics.

II. ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You may review our notice, which is displayed in the Waiting Room, posted on our website (www.mmortho.com) and available from our Front Desk staff. As provided in our notice, the terms of this notice may change. If we change our notice, you may obtain a revised copy from our Front Desk staff.

May we speak to someone other than yourself regarding your treatment?

NAME _____ RELATIONSHIP _____

III. ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

In consideration of medical services provided to me by M&M Orthopaedics, Ltd., I hereby assign M&M Orthopaedics, Ltd., its physicians and other professionals associated with the practice all of my rights and claims for reimbursement under any Medicare/Medicaid or group accident or health insurance policy for which benefits may be available for payment of the services provided. I agree to pay M&M Orthopaedics and the physician and other professionals associated with the Practice the balance due of all charges not paid for the above mentioned coverage (excluding those charges not collectable pursuant to Medicare regulation). This may include cost of collection and/or reasonable attorney fees.

IV. PATIENT FINANCIAL POLICY

I acknowledge receipt of the M&M Orthopaedics Patient Financial Policy.

I have read each of the above paragraphs and fully agree to each of the statements. I acknowledge my agreement by signing below.

PATIENT DATE _____

PARENT OR GUARDIAN (If patient is under 18 years of age) DATE _____



PATIENT'S NAME _____

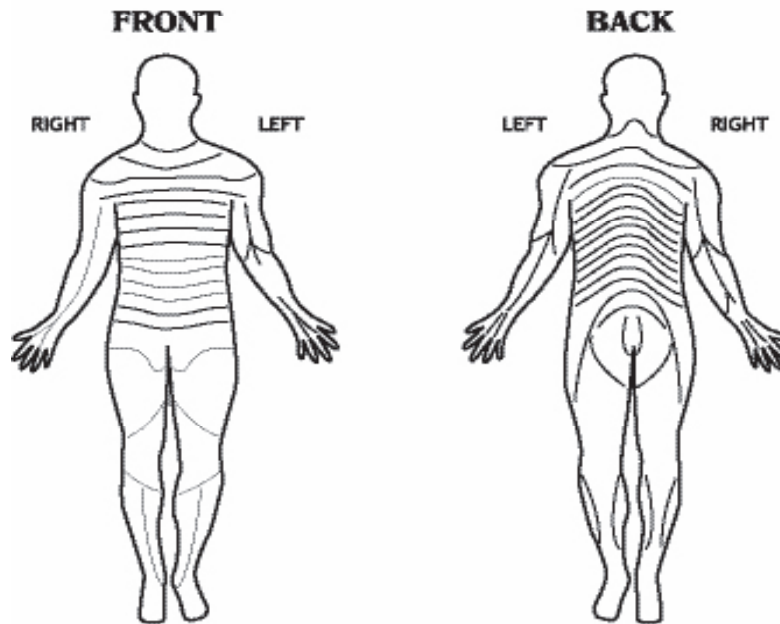
ACCOUNT NUMBER _____

How and when did your pain begin? _____

Have you had any previous episodes of back/leg, arm/neck, or other pain?

NO YES - Describe _____

Please shade areas of the body where you have pain:



HT: _____

WT: _____

Do you have any numbness, tingling, or burning in the leg/foot or arm/hand?

NO YES - Describe _____

Have you experienced any weakness in the leg/foot or arm/hand?

NO YES - Describe _____

What seems to aggravate your symptoms? _____

How far are you able to walk? _____

Are you able to drive a car? YES NO

Are you able to put on your shoes and socks? YES NO

Does coughing, straining, or sneezing bother you? YES NO

Which position is the WORST? SITTING STANDING LYING DOWN



PATIENT'S NAME _____

ACCOUNT NUMBER _____

When is the pain WORSE? MORNING NIGHT VARIES

Please indicate if you are: RIGHT HANDED LEFT HANDED

Have you had any TESTS for your current problems? _____

NO YES - When and what area of the body? _____

CT SCAN _____ MYELO _____ DISCOGRAM _____

X-RAYS _____ EMG _____ OTHER _____

MRI _____ BONE SCAN _____ OTHER _____

Your current: Height _____ Weight _____

What treatments have you had for your current problems? Indicate what type of response you had to the treat-

	NO Relief	SOME Relief	GOOD Relief
Bed Rest			
Physical Therapy			
Traction			
TENS Unit			
Spinal or Muscle Injection			
Chiropractic Treatment			
Soft Collar			
Lumbar Corset or Brace			
Application of <input type="radio"/> HEAT <input type="radio"/> ICE			
Medications (for Back or Neck)			

Please list the names of previous pain Physicians/Clinics you have seen: _____

_____ None seen in the past.



PATIENT'S NAME _____

ACCOUNT NUMBER _____

MEDICAL CONDITIONS

Have you, or your family ever had any of the following problems?

	SELF	FATHER	MOTHER	SIBLINGS
Arthritis				
Asthma				
Bleeding Problems				
Cancer (note type)				
Colitis				
Diabetes				
Difficulty in Urinating				
Emphysema				
Glaucoma				
Gout				
Heart Attack				
Heart Disease				
Hepatitis				
High Blood Pressure				
HIV				
Kidney, Bladder, Prostate problems				
Lung Disease				
Osteoporosis				
Parkinson's Disease				
Rheumatoid Arthritis				
Seizures				
Sickle Cell Anemia				
Sleep Apnea				
Thyroid Disorder				
Ulcer				
Other				

Your current: Height _____ Weight _____

ALLERGIES Please identify what you are allergic to and what type of reaction you have:

- MEDICATIONS _____ REACTION _____
- FOODS _____ REACTION _____
- IODINE (topical) _____ REACTION _____
- IODINE (injectable) _____ REACTION _____
- LATEX _____ REACTION _____
- ADHESIVES _____ REACTION _____
- OTHER _____ REACTION _____
- NO KNOWN ALLERGIES



PATIENT'S NAME _____

ACCOUNT NUMBER _____

MEDICATIONS I take the following medications:

(All prescriptions and over-the-counter, including aspirin and birth control pills):

_____	_____
_____	_____
_____	_____
_____	_____

HERBAL SUPPLEMENTS _____

OPERATIONS, TREATMENTS, HOSPITALIZATIONS

I have had the following Operations, Treatments and/or Hospitalizations:

_____	DATE _____
_____	DATE _____
_____	DATE _____

SOCIAL HISTORY

Do you use any of the following assistive devices? GLASSES CONTACTS HEARING AIDES
 PROSTHETIC LIMBS CANE WALKER

Smoking (Complete if age 13 and greater)

CURRENT SMOKER FORMER SMOKER NEVER SMOKED

Current Smoker

How many cigarettes do you smoke per day?

5 or less 6-10 11-20 21-30 31 or more

How soon after you wake up do you smoke your first cigarette?

Within 5 minutes 6-30 min 31-60 min after 60 min

Are you interested in quitting?

Ready to quit Thinking about quitting Not ready to quit

Former smoker

How long has it been since you last smoked?

1-3 months < 1 month 3-6 months 6-12 months 1-5 years 5-10 years > 10 years

Do you use smokeless tobacco? (Complete if age 13 and greater)

NO If you quit smokeless tobacco, when did you quit? _____

YES What do you use? _____ Number of years using smokeless tobacco? _____

Do you drink alcoholic beverages? NO YES—HOW OFTEN

1 DRINK PER MONTH 1-2 DRINKS PER WEEK 2-6 DRINKS PER WEEK 6 DRINKS OR MORE PER WEEK

Do you use recreational drugs? NO YES (Please list) _____

Evaluation for Falls. (Complete if age 50 and greater)

No falls, no injury?

Fall in past year or fall with injury? How many? _____

Screened for Osteoporosis (Bone Mineral Density Test, DEXA Scan)? When? _____



PATIENT'S NAME _____

ACCOUNT NUMBER _____

Are you currently pregnant? NO YES (Please list) _____

Are you planning a pregnancy? NO YES (Please list) _____

Have you experienced difficulty in sleeping due to your pain? YES NO

What type of mattress do you sleep on? SOFT MEDIUM HARD WATERBED

How many pillows do you use? _____

Have you lost weight because of your neck/back problems? YES NO

Have you suffered headaches in conjunction with your neck pains? YES NO

If yes, how often? _____

Do you have bowel or bladder problems? YES NO

If yes, what type? _____

Do you have any **UNUSUAL** visual problems? YES NO

If yes, what type? _____

Have you experienced any hearing loss? RIGHT LEFT BOTH NONE

Do you notice a buzzing/ringing in your ears? RIGHT LEFT BOTH NONE

Have you noticed any decrease in **TASTE** or **SMELL**? YES NO

What type of work do you do? _____

How long have you worked at your present job, or the job you last had? _____

If you have **NOT** been able to work because of your neck/back problem when was the **FIRST DAY** of your disability? _____

What is the **MAIN** reason you are off work? _____

On a scale of 1-10 (1 being slight pain, 10 being severe pain) what number would you consider yourself?

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

Do you have any other problems or comments? _____



M&M ORTHOPAEDICS

Extraordinary Outcomes

PAIN HISTORY FORM

DR. ELLEN VORONOV

DR. MARTIN FETZER

PATIENT'S NAME _____

ACCOUNT NUMBER _____

PLEASE PROVIDE:

Pharmacy Name: _____

Pharmacy Address: _____

Phone: _____ Fax: _____

Mail Order Pharmacy Name: _____

Mail Order Pharmacy Address: _____

Phone _____ Fax: _____

THE ABOVE LISTED INFORMATION IS CORRECT TO THE BEST OF MY ABILITY:

PATIENT SIGNATURE _____ DATE: _____

PHYSICIAN CO-SIGNATURE _____ DATE: _____