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 ( )

PRIMARY INSURANCE POLICY HOLDER'S INFORMATION

NAME OF SUBSCRIBER (POLICY HOLDER)	SEX	DATE OF BIRTH	PATIENT RELATIONSHIP TO INSURED: o SPOUSE o FOSTER CHILD/GUARDIAN o 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: o SPOUSE o FOSTER CHILD/GUARDIAN o 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

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

ETHNICITY

o HISPANIC OR LATINO o NOT HISPANIC OR LATINO

LANGUAGE

o ENGLISH o OTHER o INDIAN (INCLUDES HINDI & TAMIL) o SPANISH o RUSSIAN

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CONSENT FOR TREATMENT & FINANCIAL POLICY

PATIENT'S NAME ____________________

ACCOUNT NUMBER ____________________

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.

____________________ DATE ____________________
PATIENT

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

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PEDIATRIC HEALTH HISTORY - INITIAL EVALUATION

KAMAL IBRAHIM, M.D., FRCS(C)
MATTHEW J. BUECHE, M.D.
E. BRIAN LINDELL, M.D.

PATIENT'S NAME ____________________

ACCOUNT NUMBER ____________________

PATIENT HISTORY

Please answer all questions as completely as possible. This will aid the doctor with the examination, will ensure a thorough history, and will expedite your visit. If any question is not applicable, please write N/A. Please have this with you for your appointment. We thank you for your patience.

DATE OF VISIT ____________________

PATIENT NAME ____________________

DATE OF BIRTH ____/____/____ AGE ________ GENDER: M F

Who referred you to this office? ____________________

Who is the patient's Primary Care Physician? ____________________

Physician's Phone Number: ____________________

CHIEF COMPLAINT

What health problem brings your child in today (the chief complaint)? ____________________

____

____

How long has the problem been present? ____________________

How did it start? Was there any injury or obvious cause? ____________________

____

Has there ever been a similar condition prior to this? Is there a similar condition elsewhere in the body?

____

____

Has any treatment been received? o YES o NO If yes, please explain: ____________________

____

Who prescribed it? ____________________ For how long? ____________________

Did the treatment help? o YES o NO ____________________

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PATIENT'S NAME ______________________________

ACCOUNT NUMBER ______________________________

PRESENT HISTORY

PAIN

Does this patient have pain? o YES o NO

When is the pain most likely to occur? o MORNING o EVENING o CONSTANT

o AWAKENS CHILD FROM SLEEP o AT REST o DURING PHYSICAL ACTIVITY

How long does the pain last? ______________________________

What makes the pain worse? ______________________________

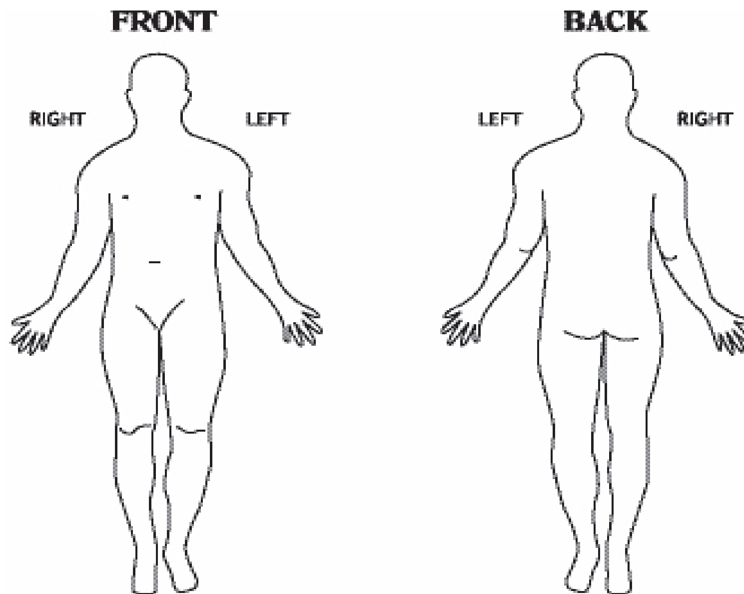
What relieves the pain (including medicines)? ______________________________

____

Does the pain stay in one place or does it move? ______________________________

____

Please indicate the site of the pain on the diagram below:



DEFORMITY

Please indicate areas of concern and give details

Spinal Deformity? o YES o NO

Do you see side-to-side curvature (scoliosis) or an excessively rounded back (kyphosis)? Please explain:

____

Limb Deformity? o YES o NO Please explain: ______________________________

____

Foot Deformity? o YES o NO Are the feet? o TURNED IN o TURNED OUT o FLAT

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PATIENT'S NAME ______________________________

ACCOUNT NUMBER ______________________________

PRESENT HISTORY (continued)

Does the patient limp? o YES o NO When and for how long? ______________________________

____

Is there any joint swelling? o YES o NO

Is there limitation of motion of a joint (stiffness)? o YES o NO ______________________________

____

Is there any difficulty with balance and coordination or with frequent falling? o YES o NO

Is there any difficulty with running and sports and keeping up with peers? o YES o NO

Please explain: ______________________________

____

Does the child have any neuromuscular condition such as cerebral palsy, muscle or nerve disease? o YES o NO

____

Please add any further comments or concerns related to your child's condition not directly noted above?

____

____

____

X-RAYS

Have x-rays or other imaging tests (CT, MRI, or Ultrasound) been performed? o YES o NO

What part of the body was x-rayed? ______________________________

____

Where and when was it performed? ______________________________

____

Patient's current: Height ______________ Weight ______________

Please be sure to bring the actual films with you so that the doctor can review them. Radiologist's reports are frequently insufficient. Lack of access to tests already performed often unnecessarily delays diagnosis and treatment.

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PATIENT'S NAME ____________________

ACCOUNT NUMBER ____________________

PAST MEDICAL HISTORY

Birth Order. Where does the child fall in the order of his/her siblings (e.g. second of five) ________ of ________

Any problems with the pregnancy? o YES o NO ____________________

Any problems with the delivery? o YES o NO ____________________

Was the delivery at term? o YES o NO ______wks.

Cesarean section? o YES o NO If yes, why? ____________________

Breech position? o YES o NO

Birth Weight ____________________

Did the baby have distress after the delivery? o YES o NO ____________________

____

Milestones. Please recall when the child first:

sat independently: ____________________

walked: ____________________

Girls: Have menstrual periods begun? o YES o NO When was the first period? ______/______

Previous Hospitalizations o YES o NO

Year ______ Reason ____________________ Outcome ____________________

Year ______ Reason ____________________ Outcome ____________________

Year ______ Reason ____________________ Outcome ____________________

Previous Surgeries o YES o NO

Year ______ Reason ____________________ Outcome ____________________

Year ______ Reason ____________________ Outcome ____________________

Year ______ Reason ____________________ Outcome ____________________

Other serious medical problems, past or present? ____________________

____

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PATIENT'S NAME ______________________________

ACCOUNT NUMBER ______________________________

List any medications, even non-prescription meds, and supplements that the child takes

Medication	Dose	Frequency	Reason

Medication Allergies

Medication	Year allergy discovered	Nature of Reaction (rash, hives, etc)

Are the child's immunizations current? o YES o NO

REVIEW OF SYSTEM Please check any symptoms your child has and elaborate below

General o FATIGUE o WEIGHT LOSS o LOSS OF APPETITE o FEVER

Head, Ears, Eyes, Nose, Throat o HEARING LOSS o VISUAL LOSS o STRABISMUS o SORE THROAT

Skin o RASHES o UNUSUAL BIRTHMARKS

Endocrine Glands o NECK MASSES o CHANGE IN ENERGY LEVEL o INTOLERANCE TO COLD

Respiratory o SHORTNESS OF BREATH o WHEEZING o PERSISTENT COUGH

Cardiac o CHEST PAIN o HEART MURMUR

Gastrointestinal o ABDOMINAL PAIN o VOMITING o CONSTIPATION o DIARRHEA o BLOODY STOOLS

Genitourinary o PAIN ON URINATION o LOSS OF BLADDER CONTROL

Neurological o WEAKNESS o NUMBNESS o SEIZURES o DIZZINESS o HEADACHES
o HYPERACTIVITY/ADD o DEVELOPMENTAL DELAY

FAMILY HISTORY Please indicate if any of the following conditions are present in the family, and in whom

	Parents	**Siblings**
A condition similar to the patient's		
Juvenile Rheumatoid Arthritis		
A muscle or nerve condition, including muscular dystrophies		
Cerebral Palsy		
Chromosomal Disease		
Scoliosis or Spinal Deformity		
Congenital Deformities or Birth Defects		
Extreme Short or Tall Stature		

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PATIENT'S NAME ____________________

ACCOUNT NUMBER ____________________

SOCIAL HISTORY

Answer only those questions which apply to the child's age and situation as they relate to the child.

Does patient use any of the following assistive devices? o GLASSES o CONTACTS o HEARING AIDES
o PROSTHETIC LIMBS o CANE o WALKER o LEG BRACES

Smoking (Complete if age 13 and greater)

o CURRENT SMOKER o FORMER SMOKER o NEVER SMOKED

Current Smoker

How many cigarettes does the patient smoke per day?

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

How soon after patient wakes up do they smoke their first cigarette?

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

Is the patient interested in quitting?

o Ready to quit o Thinking about quitting o Not ready to quit

Former smoker

How long has it been since patient last smoked?

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

Does the patient use smokeless tobacco? (Complete if age 13 and greater)

o NO If patient quit smokeless tobacco, when did they quit? ____________________

o YES What does the patient use? ____________________ Number of years using smokeless tobacco? _____

Does the patient drink alcoholic beverages? o NO o YES—HOW OFTEN

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

Does the patient use recreational drugs? o NO o YES (Please list)

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/PARENT SIGNATURE ____________________ DATE: ____________________

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