



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 _____

Extraordinary Outcomes

PATIENT'S NAME _____ DATE OF BIRTH ____/____/____ AGE _____ SEX: M F

Who referred you to M&M? _____

Family Physician: _____ Physician's Phone Number _____

PLEASE STATE COMPLAINTS YOU WILL BE ASKING YOUR PHYSICIAN TO EVALUATE

MEDICATIONS I take the following medications:

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

HERBAL SUPPLEMENTS _____

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				



PATIENT'S NAME _____

ACCOUNT NUMBER _____

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

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) _____



PATIENT'S NAME _____

ACCOUNT NUMBER _____

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? _____

Your current: Height _____ Weight _____

IS THIS A WORKMEN'S COMPENSATION INJURY? YES NO (If no, proceed to page)

if you answered yes, describe how the injury occurred _____

Date of injury _____

Last day of work _____

Previous workmen's compensation claims (Year of injury and surgery required)

Name of your attorney for making your file accessible:

Associated symptoms (Check all that apply)

- PAIN TINGLING WEAKNESS **IN MY:** ARMS/HANDS LEGS/FEET
- OR OTHER _____

Timing of symptoms (Check all that apply) Pain is increased: SITTING STANDING WALKING

- LYING DOWN LEGS/FEET **IN MY:** NECK BACK ARM LEG OTHER

Rate your pain (On a scale of 0-10) 0 = No Pain 10 = Maximum Pain _____

Previous treatment for this injury (List medications, physical therapy, cortisone/epidural injections, chiropractic treatment, etc.) _____

What can't you do because of your pain? _____

Is surgery an option for you if your condition fails? YES NO

Not-operative treatment? YES NO

Do you use any of the following assistive devices? (Check all that apply)

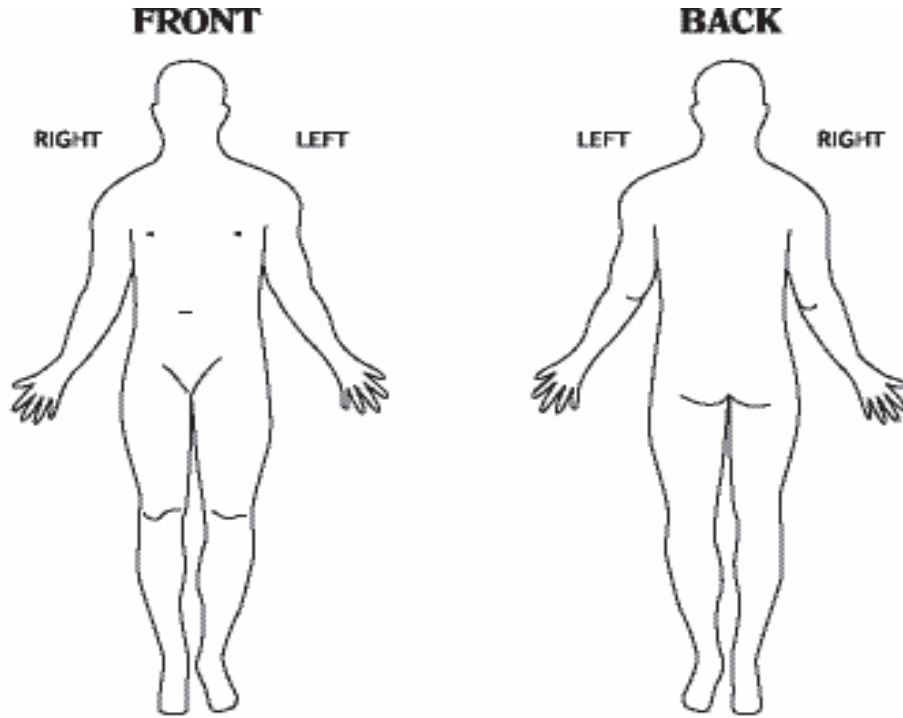
- GLASSES CONTACTS HEARING AIDES PROSTHETIC LIMBS CANE WALKER



PATIENT'S NAME _____

ACCOUNT NUMBER _____

PLEASE DRAW ON THE FIGURE BELOW WHERE YOUR PAIN IS, WHERE IT RADIATES, AND WHAT TYPE OF PAIN IT IS NUMBNESS ===== PINS & NEEDLES ++++++ BURNING XXXXX STABBING \\\



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: _____