M&M ORTHOPAEDICS

Extraordinary Outcomes

DATE ______________________

FOR OFFICE USE ONLY

ACCT# ______________________

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		

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE NUMBER
		( )

PRIMARY INSURANCE INFORMATION

NAME OF SUBSCRIBER (POLICY HOLDER)	SEX	DATE OF BIRTH	PATIENT RELATIONSHIP TO INSURED: ☐ SPOUSE ☐ FOSTER CHILD/GUARDIAN ☐ CHILD
POLICY HOLDER'S STREET ADDRESS			HOME PHONE NUMBER ( )
CITY, STATE, ZIP CODE			SOCIAL SECURITY NUMBER
EMPLOYER			EMPLOYER'S PHONE NUMBER ( )
EMPLOYER'S ADDRESS (CITY, STATE, ZIP CODE)			OCCUPATION

SECONDARY INSURANCE INFORMATION

NAME OF SUBSCRIBER (POLICY HOLDER)	SEX	DATE OF BIRTH	PATIENT RELATIONSHIP TO INSURED: ☐ SPOUSE ☐ FOSTER CHILD/GUARDIAN ☐ CHILD
POLICY HOLDER'S STREET ADDRESS			HOME PHONE NUMBER ( )
CITY, STATE, ZIP CODE			SOCIAL SECURITY NUMBER
EMPLOYER			EMPLOYER'S PHONE NUMBER ( )
EMPLOYER'S ADDRESS (CITY, STATE, ZIP CODE)			OCCUPATION

PRIMARY CARE PHYSICIAN or FAMILY PHYSICIAN

NAME	PHONE NUMBER ( )
CITY, STATE, ZIP CODE	

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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.

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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PATIENT SOCIAL & FAMILY HISTORY

PATIENT'S NAME ____________________

Who referred you to this office? ____________________

Who is your Primary Care Physician? ____________________

Physician's Address: ____________________ Physician's Phone 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

MEDICATIONS

I take the following medications:
(All prescriptions and over-the-counter, including aspirin, herbal supplements and birth control pills):

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

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

Do you smoke? (Complete if age 12 and greater)

☐ NO If you have quit smoking, when did you quit? (Month and year) ____________________

☐ YES Number of packs per day __________ Number of years smoking ____________________

Do you use smokeless tobacco? (Complete if age 12 and greater)

☐ NO If you quit smokeless tobacco, when did you quit? ____________________

☐ YES What do you use? ____________________ Number of years using smokeless tobacco? __________

M&M ORTHOPAEDICS

Extraordinary Outcomes

PATIENT'S NAME ______________________________

PATIENT SOCIAL & FAMILY HISTORY

SOCIAL HISTORY *-continued-*

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) ______________________________

Are you currently pregnant? ☐ NO ☐ YES (Please list) ______________________________

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

Osteoporosis Screening? (Complete if age 65 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? ______________________________

MEDICAL CONDITIONS

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

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

PATIENT'S SIGNATURE ______________________________ DATE ______________

M&M ORTHOPAEDICS

Extraordinary Outcomes

PATIENT'S NAME ______________________________

DR. VORONOV - PAIN QUESTIONNAIRE

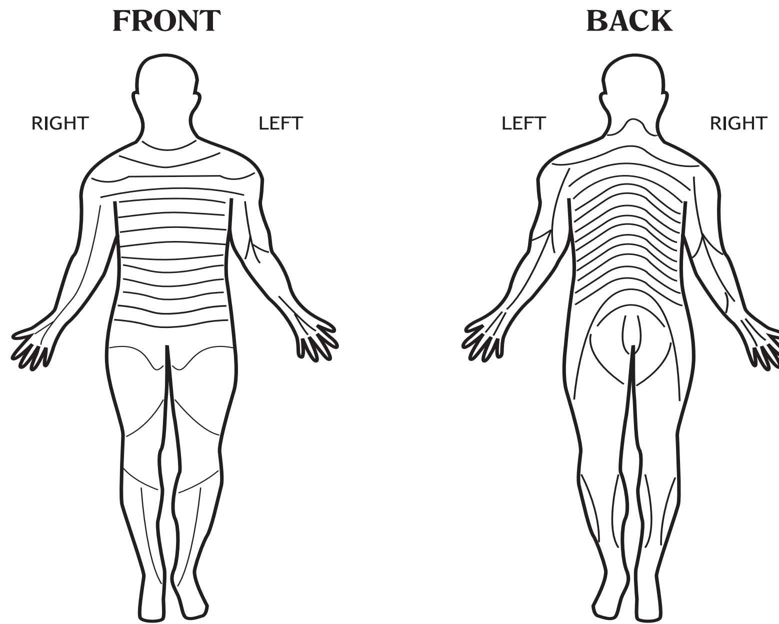
How and when did your pain begin? ______________________________

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

M&M ORTHOPAEDICS

Extraordinary Outcomes

PATIENT'S NAME ______________________

DR. VORONOV - PAIN QUESTIONNAIRE

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 ______________

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

	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 ☐ HEAT ☐ ICE			
Medications (for Back or Neck)			

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

____

____

______________________________________ ☐ None seen in the past.

M&M ORTHOPAEDICS

Extraordinary Outcomes

PATIENT'S NAME ______________________________

DR. VORONOV - PAIN QUESTIONNAIRE

MEDICAL CONDITIONS

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Rheumatoid Arthritis			
Parkinson's Disease			
Seizures			
Diabetes			
Thyroid Disorder			
Bleeding Problems			
Sickle Cell Anemia			
Hepatitis			
HIV			
Cancer (note type)			
Sleep Apnea			

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PATIENT'S NAME ______________________________

DR. VORONOV - PAIN QUESTIONNAIRE

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☐ LATEX ______________________ REACTION ______________________

☐ ADHESIVES ______________________ REACTION ______________________

☐ OTHER ______________________ REACTION ______________________

☐ NO KNOWN ALLERGIES

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

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☐ NO If you have quit smoking, when did you quit? (Month and year) ______________________

☐ YES Number of packs per day __________ Number of years smoking ______________________

Do you use smokeless tobacco? (Complete if age 12 and greater)

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☐ YES What do you use? ______________ Number of years using smokeless tobacco? __________

Do you drink alcoholic beverages? ☐ NO ☐ YES—HOW OFTEN

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PATIENT'S NAME ______________________

DR. VORONOV - PAIN QUESTIONNAIRE

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 is **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? ______________________

____

____

____

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

PATIENT SIGNATURE ______________________ DATE: ______________

PHYSICIAN CO-SIGNATURE ______________________ DATE: ______________