



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 ()
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PRIMARY INSURANCE INFORMATION

NAME OF SUBSCRIBER (POLICY HOLDER)	SEX	DATE OF BIRTH	PATIENT RELATIONSHIP TO INSURED: <input type="checkbox"/> SPOUSE <input type="checkbox"/> FOSTER CHILD/GUARDIAN <input type="checkbox"/> 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: <input type="checkbox"/> SPOUSE <input type="checkbox"/> FOSTER CHILD/GUARDIAN <input type="checkbox"/> 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.

PATIENT DATE _____

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



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? YES NO If yes, please explain: _____

Who prescribed it? _____ For how long? _____

Did the treatment help? YES NO _____



PATIENT'S NAME _____

PRESENT HISTORY

PAIN

Does this patient have pain? YES NO

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

AWAKENS CHILD FROM SLEEP AT REST DURING PHYSICAL ACTIVITY

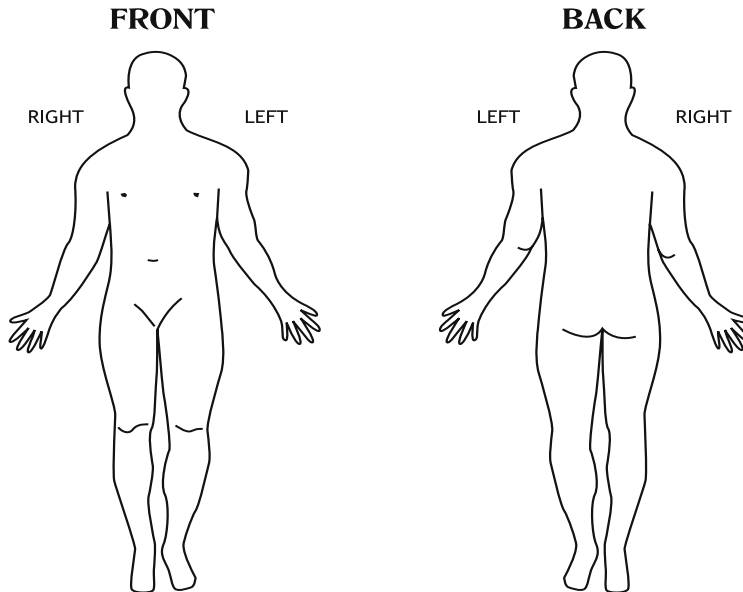
How long does the pain last? _____

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? YES NO

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

Limb Deformity? YES NO Please explain: _____

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



PATIENT'S NAME _____

PRESENT HISTORY (continued)

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

Is there any joint swelling? YES NO

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

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

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

Please explain: _____

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

What part of the body was x-rayed? _____

Where and when was it performed? _____

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.



PATIENT'S NAME _____

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? YES NO _____

Any problems with the delivery? YES NO _____

Was the delivery at term? YES NO _____ wks.

Cesarean section? YES NO If yes, why? _____

Breech position? YES NO

Birth Weight _____

Did the baby have distress after the delivery? YES NO _____

Milestones. Please recall when the child first:

sat independently: _____

walked: _____

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

SOCIAL HISTORY

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? _____

Previous Hospitalizations YES NO

Year _____ Reason _____ Outcome _____

Year _____ Reason _____ Outcome _____

Year _____ Reason _____ Outcome _____

Previous Surgeries YES NO

Year _____ Reason _____ Outcome _____

Year _____ Reason _____ Outcome _____

Year _____ Reason _____ Outcome _____

Other serious medical problems, past or present? _____



PATIENT'S NAME _____

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? YES NO

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

General FATIGUE WEIGHT LOSS LOSS OF APPETITE FEVER

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

Skin RASHES UNUSUAL BIRTHMARKS

Endocrine Glands NECK MASSES CHANGE IN ENERGY LEVEL INTOLERANCE TO COLD

Respiratory SHORTNESS OF BREATH WHEEZING PERSISTENT COUGH

Cardiac CHEST PAIN HEART MURMUR

Gastrointestinal ABDOMINAL PAIN VOMITING CONSTIPATION DIARRHEA BLOODY STOOLS

Genitourinary PAIN ON URINATION LOSS OF BLADDER CONTROL

Neurological WEAKNESS NUMBNESS SEIZURES DIZZINESS HEADACHES
 HYPERACTIVITY/ADD 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		

PATIENT/PARENT SIGNATURE _____ DATE _____