



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: <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	



M&M ORTHOPAEDICS

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.

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 _____ DATE OF BIRTH ____/____/____ AGE _____ SEX: M F

Who referred you to us? _____

Family Physician: _____ Physician's Phone Number _____

PLEASE STATE COMPLAINTS YOU WILL BE ASKING YOUR PHYSICIAN TO EVALUATE

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 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 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? _____



PATIENT'S NAME _____

M&M ORTHOPAEDICS

INITIAL PATIENT VISIT - SPINE

Extraordinary Outcomes

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) _____

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			

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:



PATIENT'S NAME _____

M&M ORTHOPAEDICS

INITIAL PATIENT VISIT - SPINE

Extraordinary Outcomes

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

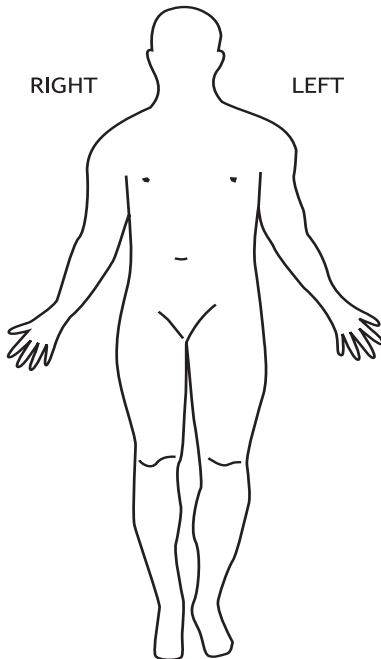
Not-operative treatment? YES NO

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

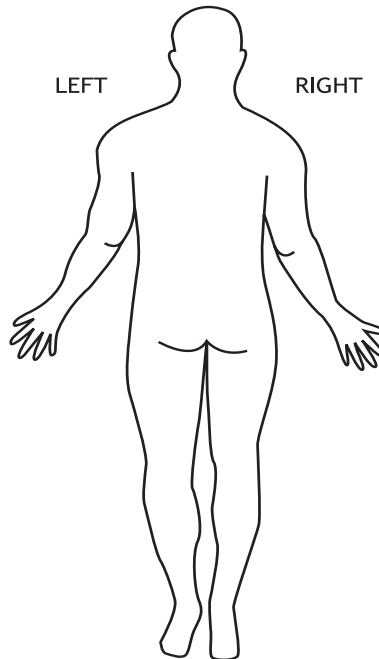
GLASSES CONTACTS HEARING AIDES PROSTHETIC LIMBS CANE WALKER

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 \\\

FRONT



BACK



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

PATIENT'S SIGNATURE _____ DATE _____

PHYSICIAN CO-SIGNATURE _____ DATE _____