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 SIDNEY L. BAILEY, M.D.
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 GRANT A. DONA, M.D.
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 R. BRIAN BULLOCH, M.D.
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 BERNIE CALDWELL, PA-C
 CHRIS DeMENT, ANP-C

(A Medical Corporation)
 PRACTICE LIMITED TO ORTHOPAEDIC SURGERY
 ESTABLISHED IN 1951
 www.monroeortho.com

KEVIN P. GOLDMAN, CEO, CPA

Dr.'s Name: _____

| | | | | | |
|--|-----|------------------------------|-----------------------------------|-------------------------------|---------------------|
| Patient Information | | Patient # | Appt. Date | Social Security # | Driver's License # |
| First Name | | Middle Name | | Last Name | Sex M F |
| Date of Birth | Age | Marital Status | Race/Ethnicity | Patient's Employer | Work Phone # |
| Patient's Mailing Address | | | | City | State Zip |
| Patient's E-mail Address | | Home Phone # | Cell Phone # | Spouse's Name | |
| Referring Doctor's Name | | | Referring Doctor's City, State | | |
| Primary Insurance | | Insurance Company Name | | Insurance Company Address | |
| Insurance Group # | | Insurance Policy # | | Policy Holder's Name | |
| Policy Holder's Date of Birth | | | Policy Holder's Social Security # | | |
| Secondary Insurance | | Insurance Company Name | | Insurance Company Address | |
| Insurance Group # | | Insurance Policy # | | Policy Holder's Name | |
| Policy Holder's Date of Birth | | | Policy Holder's Social Security # | | |
| Guardian Information (for children) | | Guardian's Name | | | Guardian's Employer |
| Guardian Phone # | | Guardian's Social Security # | | Guardian's Driver's License # | |

Emergency Contacts:

| | | |
|-----------|--------|---------------|
| (1) Name: | Phone: | Relationship: |
| (2) Name: | Phone: | Relationship: |

ALL CHARGES ARE DUE IN FULL AT TIME OF TREATMENT

I declare that the above information is true and correct to the best of my knowledge.

I hereby make an irrevocable assignment of benefits or proceeds from any claim, health insurance, or worker's compensation in an amount sufficient to satisfy my indebtedness to the Orthopaedic Clinic of Monroe for services rendered for injuries sustained on or about _____, 20_____.

I acknowledge receipt of the Notice of Health Information Privacy Practices.

 Patient's Signature
 (Parent or guardian, if minor)

 Date

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**North Louisiana
 Orthopaedic &
 Sports Medicine Clinic**

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Patient Name _____ **Date** _____

Date of Birth _____ **Age** _____ **Height** _____ **Weight** _____ **Sex** **M** **F**

CHIEF COMPLAINT What part of the body are we checking today? _____

Please circle RIGHT or LEFT, if it applies to above question.

Date of injury or when symptoms began _____

Explain your problem _____

Have you been seen by another physician for this problem? **YES** **NO**

If yes, what physician and when? _____

Have you been seen at the emergency room for this problem? **YES** **NO**

If yes, what ER and when? _____

X-RAYS Have you had recent x-rays, scans or MRI's taken? **YES** **NO**

If yes, when and where? _____

ALLERGIES Do you have a history of latex allergy? **YES** **NO**

| Drug | Reaction | Drug | Reaction |
|------|----------|------|----------|
| 1. | | 3. | |
| 2. | | 4. | |

MEDICATIONS

| Drug | Dosage | Drug | Dosage |
|------|--------|------|--------|
| 1. | | 6. | |
| 2. | | 7. | |
| 3. | | 8. | |
| 4. | | 9. | |
| 5. | | 10. | |

Do you take diet pills or nutritional supplements? **YES** **NO**

If yes, please list the type and when last taken:

| Name | Date Last Taken |
|------|-----------------|
| 1. | |
| 2. | |

YOUR Past Medical History

| Illness | Yes | No | Illness | Yes | No | Illness | Yes | No | Illness | Yes | No | |
|---------------|-----|----|----------------------|-----|----|--------------------|-----|----|------------------------|-----|----|--|
| Hypertension | | | Diabetes | | | Osteoporosis | | | Stroke | | | |
| Angina | | | HIV | | | Gout | | | Renal Dialysis | | | |
| Heart Disease | | | Cancer | | | Sleep Apnea | | | Please list any other: | | | |
| Heart Failure | | | Rheumatoid Arthritis | | | Prostate Disorders | | | | 1. | | |
| Asthma | | | Esophageal Reflux | | | Renal Disorders | | | | 2. | | |
| COPD | | | Thrombophlebitis | | | Hepatitis | | | 3. | | | |

Patient Name _____ Date _____

Date of Birth _____

Please state your occupation and job duties. _____

Social History

Are you: Single Married Divorced Widowed

Living Arrangements: Home Alone Home with Family Assisted Living _____
 Nursing Home _____

Smoking/Smokeless Tobacco Status

Circle which applies:

Never Smoked Current Smoker Former Smoker Smokeless Tobacco Unknown

The amount and how often you use tobacco: _____

Do you drink alcohol? Regularly Occasionally No

If regularly or occasionally, please list the amount and type ingested: _____

Do you use recreational drugs? Yes No

Were you referred here? If so, by whom: _____

Family Doctor: _____

FAMILY Medical History (Do you have a family history of any of the following illnesses?)

| Yes | No | Illness | If yes, then please list the type family member (i.e. father, mother, grandmother, etc.) |
|-----|----|----------------------|--|
| | | Cancer | |
| | | Heart Disease | |
| | | Hypertension | |
| | | Osteoarthritis | |
| | | Diabetes | |
| | | Rheumatoid Arthritis | |
| | | Tuberculosis | |

PAST SURGICAL HISTORY

| Year | Name of Operation | Year | Name of Operation |
|------|-------------------|------|-------------------|
| 1. | | 6. | |
| 2. | | 7. | |
| 3. | | 8. | |
| 4. | | 9. | |
| 5. | | 10. | |

Review of Systems

| | Yes | No | | Yes | No | | Yes | No |
|--------------------------------|-----|----|----------------------------------|-----|----|-------------------------------|-----|----|
| Systemic Symptoms | | | Night sweats | | | Skin Symptoms | | |
| Weight change | | | Wheezing | | | Pruritus (itching) | | |
| Chills | | | Cardiovascular Symptoms | | | Skin lesions | | |
| Fever | | | Chest pain or discomfort | | | Rashes | | |
| Night sweats | | | Fast heart rate | | | Endocrine Symptoms | | |
| Malaise (feeling tired/poorly) | | | Palpitations | | | Excessive sweating | | |
| HEENT Symptoms | | | Gastrointestinal Symptoms | | | Excessive thirst | | |
| Headache | | | Difficulty swallowing | | | Hematological Symptoms | | |
| Eyesight problems | | | Heartburn | | | Easy bleeding | | |
| Nosebleeds | | | Nausea | | | Easy bruising tendency | | |
| Neck Symptoms | | | Vomiting | | | Neurological Symptoms | | |
| Neck Pain | | | Abdominal Pain | | | Dizziness | | |
| Neck Stiffness | | | Diarrhea | | | Vertigo | | |
| Lump or swelling in neck | | | Genitourinary Symptoms | | | Motor disturbance | | |
| Pulmonary Systems | | | Blood in urine | | | Sensory disturbance | | |
| Shortness of breath | | | Painful urination | | | Psychologic Symptoms | | |
| Cough | | | Increased urinary frequency | | | Sleep disturbances | | |
| Coughing up blood | | | Decreased kidney function | | | Anxiety | | |
| | | | | | | Depression | | |