

DOUGLAS C. BROWN, M.D.

PATIENT REGISTRATION

PLEASE PRINT AND ANSWER ALL QUESTIONS

PATIENT's Name _____ Age _____

Address _____ Last _____ First _____ Middle _____ Apt. _____ City _____ State _____

Zip Code _____ Birth Date _____ Male Female Married Single Widowed Divorced

Home Phone _____ Work Phone _____ Referring Doctor _____

How did you hear about Dr. Brown? Referring Doctor Friend Phone Book Insurance Co. Other _____

Social Security No. _____ Driver's License No. _____ Exp. _____

Employer _____ Address _____

SPOUSE NAME _____ Employer _____ Phone _____

PERSON TO CONTACT IN AN EMERGENCY _____ Phone _____

MEDICATIONS ALLERGIC TO: _____

Responsible Party Information -

INSURANCE COVERAGE - PRIMARY (Copy of your insurance card is required)

INSURANCE COVERAGE - SECONDARY (Copy of your insurance card is required)

Name of Policy Holder _____ DOB: _____ Relationship _____

Name of Policy Holder _____ DOB: _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Address _____ City _____ State _____ Zip _____

Ins. Co. _____ Address _____ City _____

Ins. Co. _____ Address _____ City _____

State _____ Zip _____ Telephone _____

State _____ Zip _____ Telephone _____

Policy _____ Group _____ Social Security # _____

Policy _____ Group _____ Social Security # _____

EMPLOYER _____ Telephone No. _____

EMPLOYER _____ Telephone No. _____

Address _____

Address _____

All professional services rendered are charged directly to the patient. The patient is responsible for all fees, regardless of insurance coverage or the status of any insurance claim(s). It is customary to pay for service at the time it is rendered.

I hereby give my consent and/or permission to any insurance carrier including Blue Cross and Blue Shield of Louisiana Medicare Services to release any additional information regarding the status of my claim(s) directly to Douglas C. Brown, M.D., a Medical Corporation.

I hereby authorize Douglas C. Brown, M.D., a Medical Corporation, to furnish information to any consulted medical providers and to my insurance carrier(s) concerning my medical history, illness(es) and treatments. I hereby authorize my insurance benefits including major medical, Medicare, private insurance and/or other health plan benefits which I, my spouse, or my dependents are entitled to, be paid directly to Douglas C. Brown, M.D. a Medical Corporation. I hereby authorize Douglas C. Brown, M.D. a Medical Corporation to release all information necessary to secure the payment(s) of these benefits. A photocopy of this assignment shall be considered as valid as the original. This assignment will remain in effect until revoked by me in writing. In the event my account is assigned to collection, I agree to pay the entire account balance plus a 33.33 % collection fee, 1.5% interest per month and a \$250.00 attorney fee if this account requires legal action.

I HAVE READ AND I UNDERSTAND THE ABOVE PARAGRAPHS

X Signature _____ Date _____

X Witness _____ Date _____

Patient Name: _____

Orthopedic History

Chief Complaint

Why are you seeing the Doctor today? _____

Your current problem is the result of a(n): **Please circle all that apply**

Vehicle Accident Work Accident Accident Other

When (roughly what date) did your present pain start? _____

Are you still working? Yes No *if no, your last day on the job was: _____

This occurred during: **Please circle all that apply**

Lifting Pulling Pushing Twisting Falling Bending
Reaching Squatting Hit by an Object Unknown

Review of Symptoms

Are you currently having or have you had problems with your:

	Circle		Please describe all Yes responses
Eyes	Yes No		_____
Ears, Nose, or Throat	Yes No		_____
Lungs/Breathing	Yes No		_____
Digestion/Bowel Movement	Yes No		_____
Bladder Problems	Yes No		_____
Diabetes	Yes No		_____
High Blood Pressure	Yes No		_____
Bleeding Problems	Yes No		_____
Balance Problems	Yes No		_____
Numbness/Tingling	Yes No		_____
Blackout/Fainting	Yes No		_____
Psychological Problems	Yes No		_____
AIDS	Yes No		_____
Cancer	Yes No		_____
Arthritis	Yes No		_____
Polio or Epilepsy	Yes No		_____
Tuberculosis (TB)	Yes No		_____

Have you ever had general anesthesia? Yes No

Have any problems with anesthesia? Yes No

*If yes, describe: _____

Patient Name: _____

Past Medical History

Surgeries/Hospitalizations	Year	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication	Dose	How Long	Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies _____

Social History

Work in the home Employed (occupation _____) Student

Do you have children? Yes No *If yes, how many? _____

Do you live alone? Yes No

How often do you exercise? Weekly Monthly Rarely Never

What type of exercise? _____

Are you on a special diet? Yes No *If yes, describe _____

History of substance abuse? Yes No *If yes, describe _____

Do you currently smoke? Yes No _____ Packs per day for _____ years

If you quit smoking, when? This year >1 year >5 years >10 years

*Previously smoked _____ Packs per day for _____ years

Do you drink alcohol? Yes No

*If yes, please circle one: Daily 1-2 times day 1-2 times month 1-2 times year

Name _____ Date: _____

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

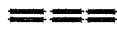
Aching



Numbness



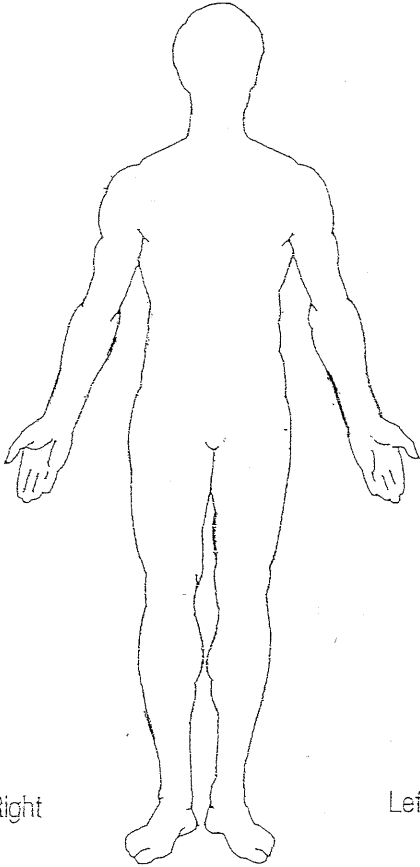
Pins and Needles



Burning



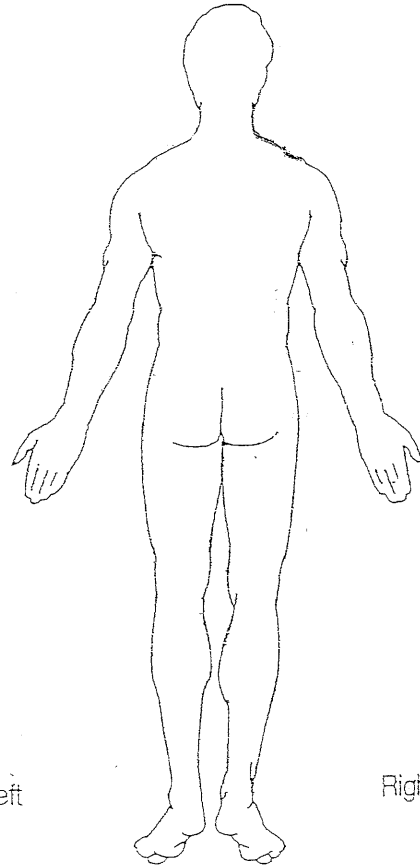
Stabbing



Right

Left

Front



Left

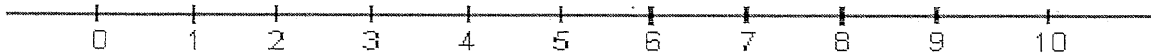
Right

Back

How Bad is your pain now?

Please mark with an x on the body where the pain is worst now

0-10 Numeric Pain Intensity Scale



Briefly describe how injury or problem occurred.
