DOUGLAS C. BROWN, M.D.

PATIENT REGISTRATION

PLEASE PRINT AND ANSWER ALL QUESTIONS

PATIENT'S Name _____ Age _____
Last First Middle

E-MAIL _____

Address _____ Apt. _____ City _____ State _____

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

Home Phone _____ Work Phone _____ Cell _____ 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)

Name of Policy Holder DOB: Relationship

Address City State Zip

Ins. Co. Address City

State Zip Telephone

Policy Group Social Security #

EMPLOYER Telephone No.

Address

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

Name of Policy Holder DOB: Relationship

Address City State Zip

Ins. Co. Address City

State Zip Telephone

Policy Group Social Security #

EMPLOYER Telephone No.

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 you 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*

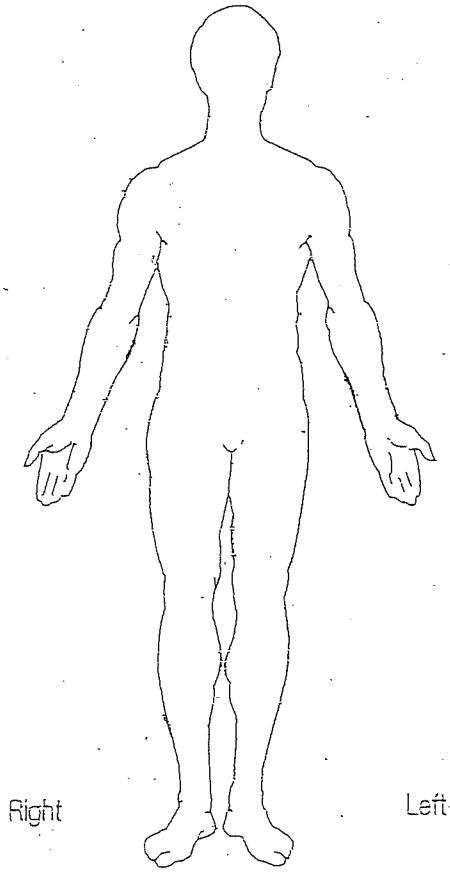
Do you drink alcohol? *Yes* *No* **If yes, please circle one:*

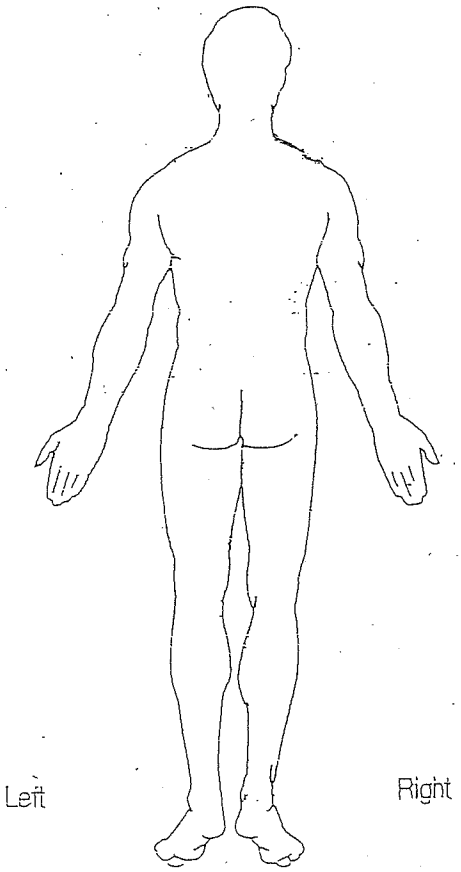
Daily *1-2 times a day* *1-2 times a month* *1-2 times a year*

Name_____ Date:_____

Where us 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 you face.

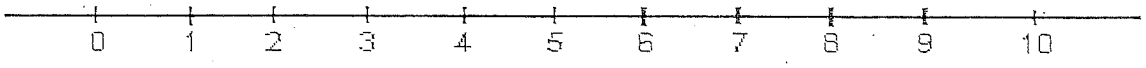
Aching	Numbness	Pins and Needles	Burning	Stabbing
▲▲▲	⬭⬭⬭	═══	X X X	/ / /





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.

_____

_____

_____

Additional Information

Patient Name: _____ DOB: _____

Race:
_____ American Indian/Alaska Native
_____ Asian
_____ Native Hawaiian or Other Pacific Islander
_____ Black or African American
_____ White
_____ Hispanic
_____ Other Race
_____ Refuse to Answer

Ethnicity:
_____ Hispanic/Latin
_____ Non-Hispanic
_____ Refuse to Answer

Language:
_____ English
_____ Indian
_____ Other
_____ Russian
_____ Spanish