SOUTHWEST ORTHOPEDIC GROUP, LLP

DATE: ______________________ **DR. NAME:** ______________________

PATIENT DATA

____ SOCIAL SECURITY NO: ________________
Last Name First Name Middle

____________________ _______ MALE OR FEMALE **Marital Status**: M S W D
Date of Birth Age

____ HOME PHONE: ______________________
Home Address Apt. No.

____________________ ________ __________ WORK PHONE: ______________________
City State Zip Code

CELL PHONE: ______________________

Occupation: ______________________________

Referred By:____ OFFICE NO.: ______________________

EMERGENCY CONTACT INFORMATION:

______________________________ PHONE NO.: __________________ RELATIONSHIP: ________________
NAME

EMPLOYER INFORMATION:

____ PHONE NO.: ______________________
EMPLOYER NAME

____ ______________________________
Address City State Zip Code

GUARANTORS INFORMATION:

____ __________________ ________________
Last Name First Name Middle Social Security Number Date of Birth

Patient's Relationship to Policy Holder: __________________________ HOME PHONE: ______________________________

____ ________________ __________ __________
Home Address Apt. No. City State Zip

INSURANCE INFORMATION

PRIMARY INSURANCE:

____ Customer Service No: ______________________
Name of Primary Insurance

______________________________ ______________________
ID NUMBER GROUP NO.

SECONDARY INSURANCE:

____ Customer Service No: ______________________
Name of Secondary Insurance

______________________________ ______________________
ID NUMBER GROUP NO.

AUTHORIZATION TO PAY BENEFITS OT PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY OTHERWISE PAYALE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT RELEASE ME FROMM MY PERSONAL RESPOBSIBILITY FOR PAYMENT OF ALL CHARGES WITHIN 50 DAYS. AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

____
SIGNATURE **DATE**

Southwest Orthopedic Group, L.L.P.
Michael G. Kaldis, M.D.

Patient Form
CERVICAL SPINE/SHOULDER

Name____ Age_______ Sex______________

Date of Evaluation_________________________ Height __________ Weight ______________

Referred by ____

List all medications you are currently taking (including vitamins, or herbs), or attach a list:

_____________________ ___________________ _____________________

_____________________ ___________________ _____________________

Drug Allergies _____Yes _____No (*if yes, please list)*

____________________ ___________________ _____________________

Date of injury (if involved in accident) _________ _______Auto accident _______On the job

Name of Employer (if work related)?____

Occupational/Physical Requirements?____

Name of Attorney involved in case?____

Mechanism of injury:

1)Twisting _____Yes _____No
2) Lifting _____Yes _____No
3) Fall _____Yes _____No
4) Blunt Trauma _____Yes _____No
5) Motor Vehicle Accident _____Yes _____No
6) Other ________________________________

Chief Complaint:

Neck pain only _____Yes _____No
Arm pain only _____Right_____Left_____Both
Neck & arm pain _____Right_____Left_____Both

When did neck pain begin? Month _____ Day _____ Year 20 _____

Character of neck pain:
_____Dull ache
_____Sharp/stabbing
_____Shooting
_____Other_____________
____

Frequency of neck pain:
_____Intermittent
_____Constant
_____Other_____________

Do you have radiation of pain into arms? ____ Yes _____No (*If yes, which arm)* _____Right _____Left _____Both

Frequency: _____Constant _____Intermittent

_____Upper Arm _____Elbow _____Forearm _____Wrist _____Hand _____Fingers

Numbness: _____Yes _____No (If yes, which arm) _____Right _____Left_____Both

Frequency _____Constant _____Intermittent

Location (Specify right/left/both as L/R/B below)

_____Upper Arm _____Elbow _____Forearm _____Wrist _____Hand _____Fingers

Tingling: _____Yes _____No _____Right _____Left _____Both

Frequency of tingling _____Constant _____Intermittent

_____Upper Arm _____Elbow _____Forearm _____Wrist _____Hand _____Fingers

What makes pain better
_____Nothing
_____Medication
_____Heat
_____Ice
_____Exercise
Other__________________
____

What makes pain wore
_____Nothing
_____Lifting
_____Reaching
_____Driving
_____Other_________________ _____
____
____

Past medical history
_____High blood pressure
_____Heart disease
_____Diabetes
_____Cancer
_____Other_______________
____

Previous surgeries:
____
____
____
____

Social History
________Smoker _____packs per day
________drugs
________Alcohol _____rarely _____occasionally ____heavy

Family History
_________________________ _____________________________

Review of systems
Do you know or have you had problems related to the following systems?

GU
____Trouble with urination
____Frequent urination
____Blood in urine

NEURO/PSYCH
____Headache
____Depression

ENT/PULMONARY
____Sore throat
____Cough
____Trouble breathing
____Chest pain

OTHER
________Fever ______°F
________Chills

GI
____Abdominal pain
____Nausea
____Vomiting
____Diarrhea
____Black/bloody stool

SKIN
____Skin rash

Have you had recent physical therapy? _____Yes _____No

Frequency/duration: ________x per week for _______weeks/months

_____Hot packs
_____Massage
_____Ultrasound
_____Neck exercise
_____Other_________
____

Improvement with physical therapy:
_____None
_____Some
_____Moderate
_____Very good

PHYSICAL EXAMINATION OF THE CERVICAL SPINE/SHOULDER
(for office use only)

APPARENT DISTRESS: Alert & oriented ( ) None ( ) Mild ( ) Moderate ( ) Severe ( )

GENERAL BODY HABITUS: Thin ( ) Obese ( ) Muscular ( )

UPPER EXTREMITIES

PASSIVE RANGE OF MOTION SHOULDER

	Right/left
Flexion	WNL
Extension	WNL
Abduction	WNL
Adduction	WNL
Internal rotation	WNL
External rotation	WNL

SHOULDER Impingement Test Tinels Test Phalens Test
Positive - Negative Positive - Negative Positive - Negative

TENDERNESS: Shoulder - right/left/both
None ( ) Mild ( ) Moderate ( ) Severe ( )

MUSCLE STRENGTH TESTING	RIGHT	LEFT
Biceps	5/5	5/5
Triceps	5/5	5/5
Deltoids	5/5	5/5
Wrist extensors	5/5	5/5
Hand Intrinsics	5/5	5/5

CERVICAL SPINE

DEFORMITY: None ( ) Scoliosis ( ) Mild ( ) Severe ( )

ACTIVE RANGE OF MOTION:
None ( ) Mild ( ) Moderate ( ) Severe ( )

TENDERNESS: Neck Paraspinous Musculature - right/ left/ both
None ( ) Mild ( ) Moderate ( ) Severe ( )

NEUROLOGICAL

DEEP TENDON REFLEXES	RIGHT	LEFT
Biceps	+2	+2
Triceps	+2	+2

ATROPHY:

IMPRESSION:

Arthritis, shoulder 716.91
Degenerative Disc/cervical 722.4
Extruded Disc/cervical 722.71
Fracture cervical/compression/closed - 805.0
HNP- cervical 722.0
Impingement syndrome 726.19
Myofascial pain syndrome 729.1
Neuropathy, ulnar 354.2
Neck pain 723.1

Carpal Tunnel Syndrome 354.0
Cervical Spondylosis 721.0
Cervical Radiculopathy 723.4
Shoulder Pain 719.41
Cervical strain 847.0

PATIENT NAME:______________________

SOUTHWEST ORTHOPEDIC GROUP, LLP

Review of Notice of Privacy Practices

Acknowledgement:

I acknowledge that I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____________________________ _______________

Patient or Personal Representative Signature **Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: ____________________________.

Financial Policy Statement

It is the policy of Southwest Orthopedic Group, L.L.P. to bill your insurance carrier as a courtesy to you; however, you are responsible for the entire bill. We require that arrangements for payment of your estimated share be made today. The insured/patient is responsible for any co-payments at the time service is rendered. If your insurance carrier does not remit payment within sixty (60) days, the balance will be due in full from you. If your insurance pays in excess of the balance of your account, we will refund the credit.

If any payment is made directly to you for services billed by Southwest Orthopedic Group, L.L.P., you recognize an obligation to promptly remit same to Southwest Orthopedic Group, L.L.P.

The above does not apply for those patients that are considered Workers' Compensation. However, be advised as a Compensation patient that you may be held responsible for your charges in the event that your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Southwest Orthopedic Group, L.L.P., I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.
The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

____________________________________ ___________________

Patient or Responsible Party **Date**