LAFAYETTE BONE AND JOINT CLINIC

(A PROFESSIONAL MEDICAL CORP.)
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ORTHOPAEDIC SURGERY
JOHN E. COBB, M.D.
LOUIS C. BLANDA, JR., M.D.
DAVID S. MULDOWNY, M.D.
MALCOM J. STUBBS, M.D.

PHYSICAL MEDICINE AND REHABILITATION
DANIEL L. HODGES M.D.

Daniel L. Hodges, M.D.

Dear ______________________________ Date ____________

We have scheduled a **EMG/NCV** appointment on ____________________ at ____:____ am/pm.

Thank you for choosing my office to provide for your medical needs. My staff and I are dedicated to providing you with the best possible treatment.

Please bring ALL medications that you are currently taking to your appointment. If you are on COUMADIN, PLAVIX, OR ASPIRIN please contact your prescribing doctor to find out if you can stop taking your medicine 5 days before testing appointment. If not, please contact Dr. Hodges nurse at extension 248 for further instructions.

You can assist us in providing efficient service by taking a few minutes to *read* and *complete* the enclosed information sheet including our office policy. You ***MUST COMPLETE*** the enclosed forms ***PRIOR*** to your office visit and bring them to this office along with any test results and any medical records pertaining to your injury. This will help avoid delaying or rescheduling your appointment.

We ask that *you* make the necessary financial arrangements prior to your appointment. This will also assist in avoiding delays.

PRIVATE PAY — We require that office visits be paid at the time the service is rendered. If you have any questions, please call Rikki at 337-267-1372.

WORKER'S COMP — Should your injury be covered by worker's compensation, advanced written verification is required from the insurance company. Please have them contact Gabby at 337-210-1237.

ATTORNEY — Should an attorney agree to pay your bills, please make sure advanced payment has been sent within 2 days of your appointment. Please call Rikki at 337-267-1372 with any questions.

Please feel free to contact the appropriate person at the number above if you have any questions.

** Our office has implemented a two (2) business day "Cancellation Policy". If you need to cancel or re-schedule your appointment, please notify us two (2) business days prior to your scheduled appointment. Lack of prior notification will result in a **$50.00 cancellation fee**. Please be advised, our office will **NOT** be able to re-schedule your appointment until the **$50.00 cancellation fee is paid in full.**

Sincerely,

Daniel L. Hodges, M.D.

New Patient Information Sheet

****Please complete and bring to your first appointment***

Patient's Name:______________________ **Date of Birth**__________ **Date Completed**__________

Home Phone____________________________ **Cell Phone**____________________________

Date of Injury____________ **Who Referred you**____

Type of Injury (On the Job, car accident, fall, etc.)____

Describe in detail when/how your pain began: (Please include the following – was it a fall, accident, or injury? What hurt? Did you have pain right after it happened? What did you land on, hit, have injured?) Use page 4 for additional information if needed.

____

____

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____

____

If you were in a work accident, please circle the following:

Did you notify your supervisor? YES NO

Was an accident report completed? YES NO

If you were in a car accident, please circle the following:

Were the police called? YES NO

Were you able to get out of the car? YES NO

Was the car able to start after the accident? YES NO UNKNOWN

Did the airbags deploy? YES NO

Were you wearing your seatbelt? YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

____

PATIENT NAME

New Patient Information Sheet

Did you go to the hospital or seek treatment anywhere? (How did you get there? By ambulance, friend, drove yourself) ____________________

What hospital did you go to or where did you seek treatment? ____________________

How long after the accident did you go to the hospital or seek treatment? (Circle one)

Immediately Couple hours later Next day Next week Other: ____________

Did the hospital do any of the following? (Circle all that apply)

X-rays Give medication CT scan MRI Surgery Injection

Treatment (Circle all that apply)

Chiropractic Care: Yes No Injections: Yes No Physical Therapy: Yes No

Please list all surgeries and injections you had: (Include the year they were performed and the doctor's name)

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

Do you have: High Blood pressure_______ Diabetes_______

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

____

PATIENT NAME

New Patient Information Sheet

What is your height:___________ What is your weight__________

Are you currently working? Yes No Retired Disabled Not working due to injuries

Circle which helps your symptoms: Ice Heat Rest Medication

Circle what makes your symptoms worse: Bending Sitting Standing Weather Changes

Do you have the following due to the pain? Depression Anxiety Sleeping problems

Describe your pain: Constant Come and Go

Since you last saw a doctor is your pain: Worse The same

Check all that describe your pain:

_____Sharp _____Aching _____Stinging

_____Dull _____Burning _____Throbbing

_____Deep _____Shooting

_____Crampy _____Stabbing

Allergies to Medication:

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

PATIENT NAME

New Patient Information Sheet

Please list ALL Medications that you are currently taking. List the name, frequency and dosage:

MEDICATIONS:

Additional information:

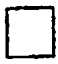
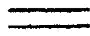
I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

PATIENT NAME

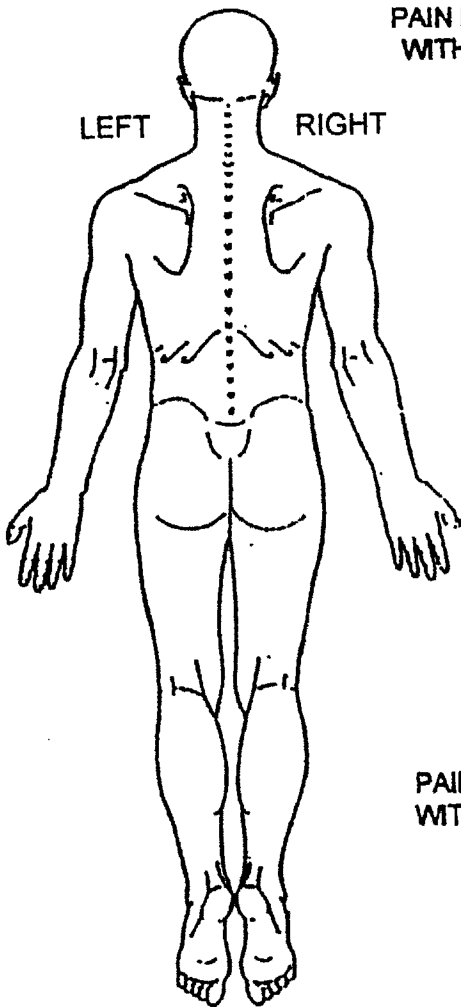
PATIENT PAIN DRAWING

NAME:______________________________DATE:____________________

USING THE SYMBOLS GIVEN BELOW, MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. INCLUDE <u>ALL</u> AFFECTED AREAS. IT IS <u>NOT</u> NECESSARY TO USE ALL THE SYMBOLS, ONLY THE ONES WHICH MOST AFFECT YOU.

ACHING	NUMBNESS	PINS & NEEDLES	BURNING	STABBING	OTHER
					

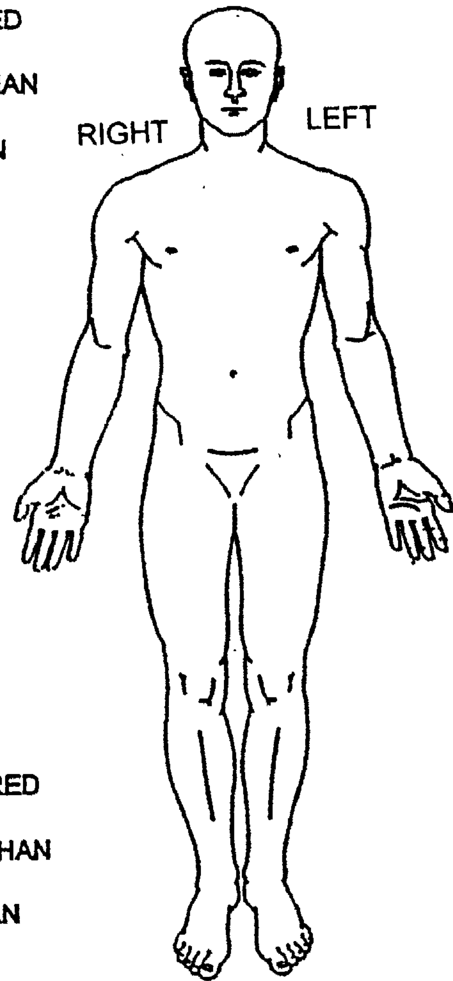
BACK



PAIN IN ARM(S) COMPARED WITH NECK:

- WORSE THAN
- SAME AS
- LESS THAN

FRONT



PAIN IN LEG(S) COMPARED WITH BACK:

- WORSE THAN
- SAME AS
- LESS THAN

CIRCLE THE QUALITY OF YOUR PAIN 0 1 2 3 4 5 6 7 8 9 10

NORMAL UNBEARABLE

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

____

PATIENT SIGNATURE