NORTHPARK ORTHOPAEDICS, P.A.

Patient's Name_____ Birthdate ___/___/_____
Marital Status (Circle One) Married Single Divorced Widow

Home Address_____
Street Address Apt #

_____
City State Zip Code

Cell Phone _____ Age _____ Sex _____

Home Phone _____ Email _____

Driver License # _____ State _____ SSN _____

Employer _____ Occupation _____

Work Phone # _____

Spouse's Name _____ Occupation _____

Spouse's Employer _____ Phone # _____

Spouse's SSN (if ins subscriber) _____ DOB _____

Family Physician _____ Phone # _____

Referred by _____

Insurance Information:

Primary Insurance Co _____Subscriber _____DOB_____

Address _____Policy # _____Grp#_____

Subscriber SSN_____ Relation to patient_____

Secondary Insurance Information

Secondary Insurance Co _____Subscriber_____DOB_____

Address_____Policy#_____Grp#_____

Subscriber SSN_____ Relation to patient_____

IT IS YOUR RESPONSIBILITY TO OBTAIN ANY REFERRAL NEEDED FROM YOUR PCP (HMO PLANS) FOR OFFICE VISITS. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MEDICAL CLAIMS.

Signed_____Date_____

NORTHPARK ORTHOPAEDICS, P.A.

Name _____ Date _____

Patient Information Sheet

CHIEF COMPLAINT_____

ONSET OF PROBLEM_____

INJURED ON JOB? Y N **AUTO**? Y N

PHYSICAL:

Height _____

Weight _____

ALLERGIES: _____

CURRENT MEDICATIONS: _____

_____

SOCIAL HISTORY:

Marital Status Single Married Divorced Widowed

Children Y N Ages/Sex _____

Employment Working Retired Unemployed Self

Alcohol Use Y N Frequency_____

Drug Use Y N

SMOKING STATUS:

( ) Never Smoker

( ) Former Smoker When did you quit? _____

( ) Current Every Day Smoker # of Packs a Day? _____

( ) Current Some Day Smoker

ILLNESSES:

Auto-Immune Disease Y N Heart Disease Y N

Arthritis Y N Hypertension Y N

Bladder Disease	Y	N	Liver Disease	Y	N
Cancer	Y	N	Lung Disease	Y	N
Cataracts	Y	N	Neuropathy	Y	N
Diabetes	Y	N	Sinusitis	Y	N
Depression	Y	N	Skin Disease	Y	N
Gallbladder Prob	Y	N	Tattoos	Y	N
Gastric Reflux	Y	N	Ulcers	Y	N
Glaucoma	Y	N			

OPERATIONS:

Appendectomy	Y	N	Hysterectomy	Y	N
Cosmetic	Y	N	Knee	Y	N
Gallbladder	Y	N	Shoulder	Y	N
Heart	Y	N	Spine	Y	N
Hip	Y	N	Tonsillectomy	Y	N

Others:_____

Any Complications with surgeries:_____

FAMILY HISTORY:

Arthritis	Y	N	Hypertension	Y	N
Cancer	Y	N	Obesity	Y	N
Cataracts	Y	N	Spine Surgery	Y	N
Diabetes	Y	N	Stroke	Y	N
Heart Disease	Y	N	Ulcers	Y	N

Is there legal involvement, or a possibility of legal involvement, in this case?

_____

Were you sent here by an attorney? Y/N If so, please give name: _____

When and where did your injury, or pain, occur? _____

_____

Were you seen in the Emergency Room? Y/N If so, when?_____

Please describe the treatment: _____

_____

Were X-rays taken? Y/N

Name any doctors you have seen before for this problem:_____

_____

HISTORY:

How did your injury occur? _____

If auto accident, please answer the following questions:

Type of collision _____ Pavement condition _____

Your position in car _____

Were you wearing a seat belt? Y/N Was the back of the seat broken? Y/N

How long have you had difficulty with your back? _____

How long have you had this particular problem? _____

How long have you been off work (if you are)? _____

Did it begin (please circle): Suddenly/Gradually/At Work

Is the pain (please circle): Continuous/Off and On/Rare

Is the pain worse in the Midmorning or Middle of the night? _____

Does your back feel that it's going to get stuck? Y/N Give way? Y/N

Is there pain in your legs upon walking? Y/N After walking? Y/N

What happens when you bend forward? _____

Do you have pain radiating down either leg?	Y/N		
If yes, please circle:	Left/Right/Both		
Do you have pain radiating down either arm?	Y/N		
If yes, please circle:	Left/Right/Both		
Does the pain change:			
With Coughing?	Better	Worse	Unchanged
With sitting?	Better	Worse	Unchanged
When seated at a table or in the car?	Better	Worse	Unchanged
When bending forward?	Better	Worse	Unchanged
When you brush your teeth?	Better	Worse	Unchanged
When walking a short distance?	Better	Worse	Unchanged
Lying flat on your back?	Better	Worse	Unchanged
Lying on your stomach?	Better	Worse	Unchanged
Lying on your side?	Better	Worse	Unchanged

SYMPTOMS:

Have you had any of the following?		
Headaches or blurring of vision	Y	N
Numbness in fingers or hands	Y	N
Difficulty in swallowing or hoarseness	Y	N
Ringing in the ears	Y	N
Dizziness	Y	N
Do you have difficulty controlling your bowel or bladder?		
Bowel	Y	N
Bladder	Y	N
Do you have loss of feeling in arms or legs?	Y	N

Location of pain: Please circle "R" for right, "L" for left. If on both sides, circle both letters. For leg and back, please specify which part of the body is in pain.

Neck	R	L
Shoulder	R	L
Arm	R	L
Elbow	R	L
Wrist	R	L
Hand	R	L
Hip	R	L
Knee	R	L
Ankle	R	L
Foot	R	L
Leg (Lower/Upper)	R	L
Back (Lower/Mid/Upper)	R	L

HAVE YOU HAD ANY OF THE FOLLOWING FOR THIS SPINAL CONDITION?

Medications: Y N If yes, what medications? _____

PT/Exercise/TENS: Y N

Brace: Y N

Epidural/Facet Inject: Y N

Have any of these helped? Y N If yes, which ones? _____

DOES THIS SPINAL CONDITION AFFECT?

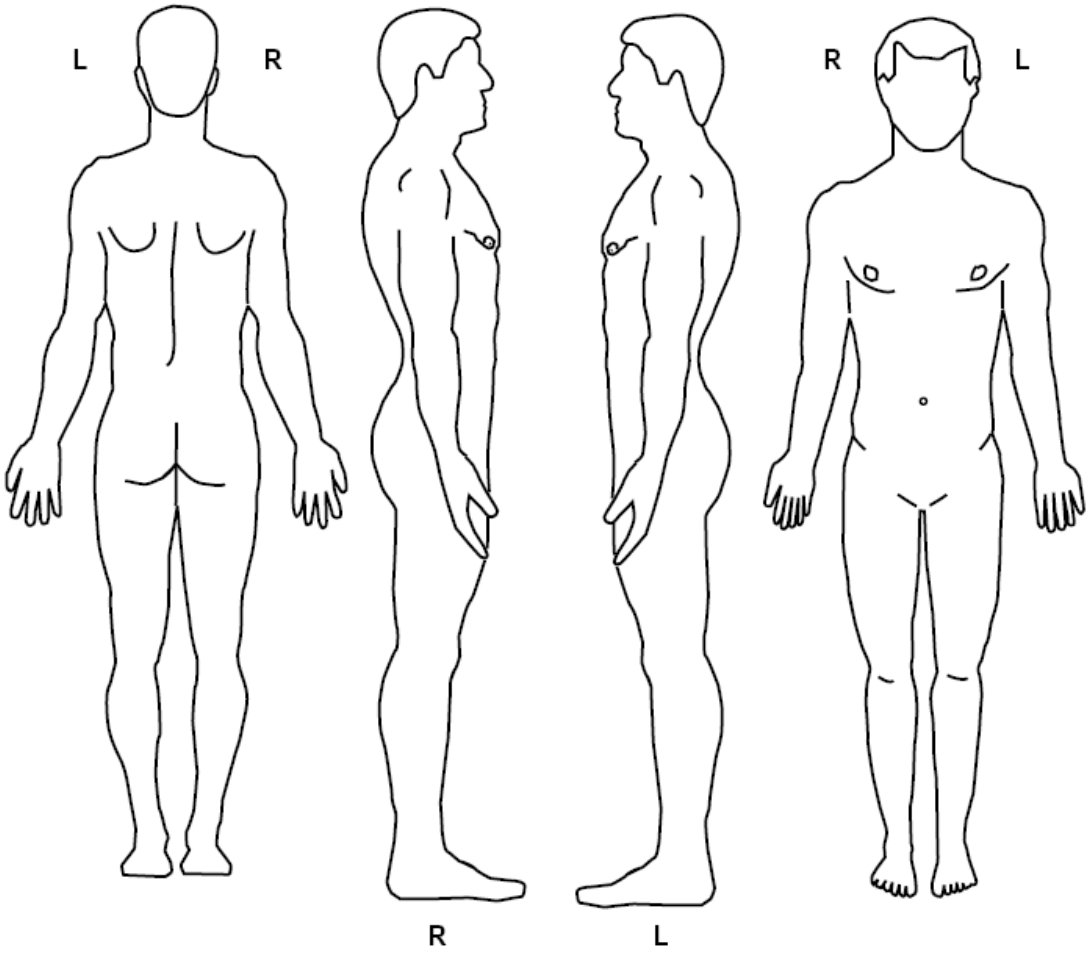
Quality of Life	Y	N	Dressing	Y	N
Lifting	Y	N	Walking/Running	Y	N
Sitting	Y	N	Standing	Y	N
Sleeping	Y	N	Traveling	Y	N

PAIN DRAWING

Name: _____ Date: _____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate letter(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness = N Pins & Needles = P Burning = B Stabbing = S Aching = A Stiffness = F



VISUAL ANALOGUE SCALE

Please circle the pain level that most accurately represents your pain.
0 = no pain and 10 = unbearable pain.

a) Right Now:----	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
b) At Worst-------	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

NAME _____ **DATE** _____

REVIEW OF SYSTEMS: LOW BACK/MID BACK

Abdominal Mass	Y	N	Abdominal Pain	Y	N
Backache	Y	N	Back Pain	Y	N
Calf Pain	Y	N	Constipation	Y	N
Decr. Range of Motion	Y	N	Diarrhea	Y	N
Incontinence of Stool	Y	N	Incontinence of Urine	Y	N
Joint Pain	Y	N	Joint Stiffness	Y	N
Joint Swelling	Y	N	Leg Cramps	Y	N
Leg Weakness	Y	N	Muscle Atrophy	Y	N
Muscle Cramps	Y	N	Muscle Pain	Y	N
Night Sweats	Y	N	Physical Disability	Y	N
Swelling of Extremities	Y	N	Weakness	Y	N

REVIEW OF SYSTEMS: NECK

Arm Weakness	Y	N	Cough	Y	N
Decr. Range of Motion	Y	N	Headache	Y	N
Head Injury	Y	N	Neck Pain	Y	N
Neck Stiffness	Y	N	Neck Swelling	Y	N
Joint Pain	Y	N	Muscle Pain	Y	N
Sinus Pain	Y	N	Sore Throat	Y	N
Swollen Glands	Y	N	Visual Disturbances	Y	N

ANY OTHER SYMPTOMS: _____

NORTHPARK ORTHOPAEDICS, P.A.

Charles J. Banta, II, M.D.

By signing below, I acknowledge that I have received and read the provided **PRIVACY PRACTICES** for Northpark Orthopaedics, P.A.

Please list family members or other person, if any, along with **PHONE NUMBER**, whom we may inform about your medical condition:

NAME: _____ PHONE NUMBER: _____

NAME:_____ PHONE NUMBER:_____

TEST RESULTS:

Should Dr. Banta recommend any special testing for you, you will be given a timely **APPOINTMENT** to follow-up on the results of these tests. Face to face consultations allow better understanding of these results. **IT IS THE PATIENT'S RESPONSIBILITY TO SCHEDULE A FOLLOW UP APPOINTMENT FOR THESE RESULTS.**

FORM/DISABILITY POLICY:

Forms are completed for accounts that are in good standing. Delinquent accounts must be brought up to date. A **PREPAID FEE** of $25.00 is charged for forms that need to be filled out for disability, leave of absence, or motor vehicle accidents. **THIS DOES NOT APPLY TO FILING YOUR HEALTH INSURANCE!** Please allow 7-10 days for completion of these forms. Forms needed in less than 7-10 days, will require a **PREPAID FEE** of $50.00. A signed authorization must be provided to have any communication with these companies or persons acting on your behalf. Patients are strongly advised to not wait until the last moment to request disability forms. We cannot be responsible for delays or losses in the mail or fax. This office will mail or fax 1 (one) copy of these forms to you or the insurance company. Should another copy be needed, we will mail or fax the form to you, one time, and it is your responsibility to route the form to the appropriate party.

MEDICATION POLICY:

In accordance with the laws of the State of Texas and the Federal Drug Enforcement Agency (DEA), no refills will be provided on medicine early. Medicine should be taken only as directed and if the medicine is required more than directed, an appointment must be made to return to our office to be re-evaluated. **ALL PATIENTS REQUIRING NARCOTIC MEDICATION LONGER THAN ONE MONTH, WILL BE REFERRED OUT TO A PAIN MANAGEMENT SPECIALIST.**

I HAVE READ THE POLICIES ABOVE AND UNDERSTAND THEM AS EXPLAINED.

Signed:_____**Date:** _____

NORTHPARK ORTHOPAEDICS, P.A. **Charles J. Banta, II, M.D.**
8220 Walnut Hill Lane, Suite 608
Dallas, TX 75231
(214) 987-3434
Fax: (214) 987-3799

FINANCIAL / INSURANCE REFERRAL POLICY

PLEASE PROVIDE THE OFFICE WITH YOUR CORRECT INSURANCE INFORMATION AND REFERRALS.

In order to file your insurance claims correctly, we will need current insurance information. If we do not have the correct insurance information, no insurance contractual adjustments will be made and the patient will be responsible for all charges in full.

There is a $25.00 charge for all returned checks. After a check has been returned twice for NSF, payments to our office will be on a cash basis only.

By signing this form, I acknowledge Northpark Orthopaedics, P.A. Financial/Insurance Referral Policies and agree to them.

Signature _____

Printed Name_____

Date _____