DATE_____

LAST NAME_____FIRST_____MI_____SEX_____

SOCIAL SECURITY#_____DATE OF BIRTH_____

E-MAIL_____ HOME_____

WORK_____EXT_____

ADDRESS_____CELL_____

ZIP CODE_____CITY_____STATE_____

EMPLOYER & ADDRESS(**IF MINOR, PARENTS NAME & NUMBER**)_____

_____PHONE NUMBER_____

IN CASE OF EMERGENCY CONTACT: _____PHONE #_____

PRIMARY CARE PHYSICIAN_____WHO REFERRED YOU?_____

☐ **SINGLE** ☐ **EMPLOYED** ☐ **MARRIED** ☐ **FULL-TIME STUDENT** ☐ **PART-TIME STUDENT**

PATIENTS RACE (choose the best one that applies to you):

☐ White ☐ Black or African American ☐ Asian

☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

ETHNICITY: ☐ Not Hispanic / Not Latino ☐ Hispanic / Latino

PLEASE SIGN AND DATE

I request that payment from my insurance carrier be made either to me or on my behalf to "Rebound Orthopaedics & Sports Medicine P.S.C" and/or "Joseph J.Dobner M.D", "J.Rick Lyon M.D", or "Dana Soucy M.D." for any services furnished to me by "Rebound Orthopaedics & Sports Medicine P.S.C" and/or "Joseph J. Dobner M.D.", "J. Rick Lyon M.D", or "Dana Soucy M.D.", I understand my signature requests that payment be made and authorizes release of medical information necessary to pay this and all future claims for services rendered. By signing below I consent to treatment necessary for myself the above patient or I consent for the above patient of whom I have guardian ship of.

PATIENT SIGNATURE_____**DATE**_____

PRIMARY RESPONSIBLE PARTY

PLEASE CHECK BOX

☐ HEALTH INSURANCE ***Please Present Card at Time of Service***

☐ WORKERS COMP ***Please Present Insurance Card at Time of Service to be used as secondary to Workers Compensation.*** *I understand by not presenting my Insurance Card, I, not my Health Insurance, will be responsible for all charges upon denial.* _____

Patient's Signature

☐ MOTOR VEHICLE ***Please Present Insurance Card at Time of Service to be used as secondary to Motor Vehicle.*** *I understand by not presenting my Insurance Card, I, not my Health Insurance, will be responsible for all charges upon denial.* _____

Patient's Signature

☐ SELF PAY ☐ OTHER _____ ☐ SECONDARY INSURANCE_____

IF HEALTH INSURANCE WASN'T CHECKED PLEASE COMPLETE BILLING INFORMATION

Company you work for_____

Workers Comp/MVA Carrier_____

Address of Carrier_____

City_____State_____Zip_____

Contact Name_____Phone # of carrier_____

Claim#_____

Date of injury_____In what State did your injury occur?_____

How injury occurred and body part(s) affected _____

HEALTH INFORMATION PRIVACY PROTECTION ACT

THESE QUESTIONS ARE BEING ASKED TO FULFILL OUR COMMITMENT TO PROTECT YOUR PRIVACY.

Is there anyone other than you that we can discuss your medical information? □ Yes □ No

If Yes, to whom_____

May we contact you at home to confirm appointments, give test results and/or billing information? □ Yes □ No

May we leave a message at your home to confirm appointment, test results and/or billing information? □ Yes □ No

May we contact you at work to confirm appointments, test results and/or billing information? □ Yes □ No

If you are unavailable at work, may we leave a voice mail message or with the person answering? □ Yes □ No

IF WE HAVE PERMISSION TO LEAVE A MESSAGE AT HOMR OR WORK, WE WILL BE IDENTIFYING OURSELVES AS WELL AS WHAT OFFICE WE ARE CALLING FROM.

Upon verbal request, may we fax or mail you information concerning your health or billing information? □ Yes □ No

May we send your medical records to your Primary Care Physician? □ Yes □ No

IF YOU DO NOT WANT US TO CONTACT YOU AT HOME OR WORK, HOW MAY WE CONTACT YOU? _____

_____ _____ _____

Signature if patient/guardian/parent/POA Printed Name Date

I acknowledge receipt of the document titled: Notice of Privacy Practices

Sign Name_____ Print Name_____ Date_____

Informed Consent Agreement for Treatment with Narcotics

The purpose of this consent is to protect your access to controlled substances and to protect our ability to prescribe for you. ***Kentucky House Bill 1-2012***

I understand that there are alternative treatments to narcotics and that the goal of my treatment is to be able to tolerate my pain while my pathology is being addressed.

I understand that daily use of a narcotic increases certain risks, which include but are not limited to:
□□Addiction□□Nausea, vomiting and constipation.□□Impaired judgment, sleepiness, and confusion.□□Allergic reactions, overdose and fatal complications□□Breathing problems□□Dizziness□□Impaired ability to operate machines or drive motor vehicles□□Development of tolerance

I agree to the following guidelines:
1. I will take this medication as prescribed by my provider. I will not vary the dosage or interval without authorization from my provider.
2. I will submit to random urine or blood tests if requested by my practitioner to assess my compliance.
3. Due to the potential for misuse, I know that I will be unable to obtain early refills or replacement of lost or stolen medication. Refills will only be made during regular office hours.
4. I agree to see my physician for on-going case management and will schedule regular appointments as long as I am taking this narcotic medication.
5. I will inform/update my practitioner of all current medications and any previous narcotic addictions/problems during each encounter.
6. I will not take any narcotics from any other physician outside of Rebound Orthopaedics & Sports Medicine, P.S.C
7. If I do not follow these guidelines I understand that my treatment may be terminated. I will discuss any questions, risks, benefits and alternatives to narcotic treatment with my provider.
8. I understand that my physician will query The Kentucky All Schedule Prescription Electronic Reporting System (KASPER) in order to treat me accordingly.
9. I have read the information about Narcotics found on the back of this sheet, and agree to abide by guidelines discussed.

_____ _____

Patient Signature Date

Narcotics

- Strong pain relievers used to treat moderate to severe pain
- Include Morphine and morphine-like drugs such as methadone, oxycodone, hydrocodone, codeine and tramadol
- Are relatively safe when taken as directed by your health care provider
- Not all pain is relieved by narcotics and not all persons that have chronic pain (pain persisting longer than 6 months) should take narcotics
- You can become addicted to morphine-based drugs
- You may require a dose adjustment to get the right amount of pain relief. This is not addiction. It is just your body getting used to the drug
- Side effects can be reduced to minimal by discussion with your health care provider about dosage and frequency of intake
- **Ability to drive/operate machinery may be affected while on Narcotics!**
- Do not change your dose of Narcotics without speaking to your health care provider
- Alert your health care provider about any side effects you experience while on Narcotics
- Call your health care provider and get immediate medical help if you experience any severe side effects
- Long term use of narcotic medications can cause deceases in the body's hormonal makeup

Additional Information about Narcotics

- Use Narcotics only for the condition for which it was prescribed
- Do not use Narcotics with alcohol, sleeping medication, or tranquillizers.
- Talk to your health care provider about any other drugs you may be taking
- Women who are pregnant or may become pregnant should talk to their health care provider before taking Narcotics
- Keep Narcotics out of reach of children, accidental overdose by a child may result in death
- Narcotics can cause constipation
- Keep your Narcotics in a safe place, as they may be a target for theft. Lost or stolen prescriptions **WILL NOT** be replaced.
- Do not take other medications without the approval of your health care provider
- Do not take Narcotics if. . .
    - Your health care provider did not prescribe Narcotics for you
    - You are allergic to the specific medicine in the Narcotic
    - You have severe asthma or other breathing problems
    - You have a bowel obstruction or a blockage of the intestines
- Before taking Narcotics, tell your health care provider. . .
    - All of your medical conditions and problems
    - If you are breast-feeding
    - Any and all medicines you take

Get Medical Help Immediately if. . .

- Your breathing slows down, you feel faint, dizzy, confused, or have other unusual symptoms
- If you take too much of your Narcotic or overdose, call 911 or your local emergency number right away.

Patient Name _____

Medications, Allergies, Previous Surgeries PMH

Medications

Are you allergic to any medications?..... ☐ No ☐ Yes If Yes What? _____

☐ **I'm currently not taking any medication.** ☐ **I'm on medications but the name and dosage is unknown.**

Medication	Dosage	Prescribed For	Physician

Please list name and location of pharmacy that you would like your medications called into.

Name_____ Location_____ Phone Number_____

Allergies

Do you have allergies?..... ☐ Enviromental ☐ Sulfa Drugs ☐ Food ☐ Birds ☐ Feathers
☐ Latex ☐ Penicillin ☐ Other ☐ Eggs

Have you ever been diagnosed with the following: ☐None

☐Diabetes ☐ Stroke ☐ Fibromyalgia
☐ Heart Disease ☐ Osteoporosis ☐ Gastric Ulcer
☐ Hypertension ☐Pacemaker ☐ Rheumatoid Arthritis
☐ Renal Failure ☐ Sleep Apnea ☐ Venous Stasis/Blood Clots
☐ Smoking Addiction ☐ Alcohol & OR Drug Addiction
☐ Lung Disease ☐ Asthma ☐ Peripheral Vascular Disease
☐ COPD ☐ Multiple Sclerosis

Have you had any of the following surgeries ☐ **No Surgeries** ☐ D&C ☐ Hernia Repair
☐ Appendectomy ☐ Gall Bladder ☐ Hysterectomy
☐ Coronary Artery Byp ☐ Hemorrhoidectomy ☐ Tonsillectomy
☐ C Section ☐ Mastectomy ☐ Stents ☐ Gastric Bypass

******Orthopaedic Surgery******

☐ Ankle Date_____Left Right ☐ Knee Date_____Left Right ☐ Foot Date_____Left Right
☐ Elbow/Wrist Date_____Left Right ☐ Hip Date_____Left Right ☐Back Date_____Left Right
☐ Shoulder Date_____Left Right ☐ Hand/Fingers Date_____Left Right ☐ Arm Date_____Left Right

Do you have problems with anesthesia?..... ☐ No ☐ Yes ☐ Unknown

Are you currently being seen by a Pain Management Doctor?..... ☐ No ☐ Yes

If yes, who is your Pain Management Doctor?..... _____ Phone# _____

Patient Name _____

DOB _____

Who referred you for this appointment? _____

If you have more than one problem to discuss with the doctor, please ask receptionist for an additional form.

Primary reason for appointment?..... Body Part _____ ☐ Left ☐ Right ☐ Both

How long have you had symptoms?.....

☐ 1 Day	☐ 1 Week	☐ 1 Month	☐ 6 Months
☐ 2 Days	☐ 2 Weeks	☐ 2 Months	☐ 7 Months
☐ 3 Days	☐ 3 Weeks	☐ 3 Months	☐ 8 Months
☐ 4 Days	☐ 4 Weeks	☐ 4 Months	☐ 9 Months
☐ 5 Days	☐ 5 Weeks	☐ 5 Months	☐ Over 1 Year

In your own words how injury occurred. Date _____

_____

Was this a result from? ☐ No Particular Injury ☐ Motor Vehicle ☐ Workers Compensation ☐ Fall

How do you rate your discomfort?..... ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 *Unbearable*

Would you describe your symptoms as.....

☐ Burning	☐ Aching	☐ Stabbing	☐ Swelling	☐ Tingling
☐ Popping	☐ Clicking	☐ Grinding	☐ Snapping	☐ Going Out Of Joint
☐ Painful	☐ Numb	☐ Feels Like A Muscle Spasm		☐ Hurts at Night
☐ Weak	☐ Locking	☐ Dislocated	☐ Catching	☐ Bruised

What aggravates your symptoms?.....

☐ Walking	☐ Standing	☐ Sitting	☐ Twisting	☐ Stairs
☐ Activity in General		☐ Running	☐ Night-Time	☐ _____

What alleviates your symptoms?..... ☐ Nothing ☐ Ice /Heat ☐ Medications ☐ Rest ☐ Exercise ☐ _____

Have you had problems like this before?.... ☐ No ☐ Yes When? _____

Tests for THIS problem previously completed?

☐ None	☐ Xray	☐ Bonescan	☐ Nerve Studies	☐ MRI
	☐ PT	☐ Chiropractor	☐ Bone Dens	☐ CT

Where were your tests performed? _____

How do you rate your overall health?..... ☐ Excellent ☐ Good ☐ Average ☐ Below Average ☐ Poor

Date Completed _____

Patient Name_____

Date _____

HAVE YOU EVER BEEN TOLD YOU HAVE:			*DESCRIBE*	*Current Problem?*	
ARTHRITIS	O Yes	O No	_____	O Yes	O No
BACK / NECK INJURY	O Yes	O No	_____	O Yes	O No
FIBROSIS / FIBROMYALGIA	O Yes	O No	_____	O Yes	O No
ASTHMA / HAYFEVER / RHEUMATIC FEVER	O Yes	O No	_____	O Yes	O No
COLITIS / GALL BLADDER TROUBLE	O Yes	O No	_____	O Yes	O No
FREQUENT DIARRHEA	O Yes	O No	_____	O Yes	O No
HIATAL HERNIA / REFLUX	O Yes	O No	_____	O Yes	O No
INDIGESTION / STOMACH PAIN	O Yes	O No	_____	O Yes	O No
STOMACH ULCERS	O Yes	O No	_____	O Yes	O No
"YELLOW" JAUNDICE / LIVER DISEASE / HEPAT	O Yes	O No	_____	O Yes	O No
ANEMIA / LOW BLOOD COUNT	O Yes	O No	_____	O Yes	O No
BLOOD TRANSFUSION	O Yes	O No	_____	O Yes	O No
CANCER	O Yes	O No	_____	O Yes	O No
EASY BRUISING	O Yes	O No	_____	O Yes	O No
EXTRA HEART BEATS (ARRYTHMIA/IRREG)	O Yes	O No	_____	O Yes	O No
PHLEBITIS / BLEEDING / CLOTTING PROBLEM	O Yes	O No	_____	O Yes	O No
SICKLE CELL DISEASE / TRAIT	O Yes	O No	_____	O Yes	O No
SWELLING OF ANKLES	O Yes	O No	_____	O Yes	O No
VARICOSE VEINS	O Yes	O No	_____	O Yes	O No
DIFFICULT SLEEPING / SLEEP APNEA	O Yes	O No	_____	O Yes	O No
LUNG BLOOD CLOT / PULMONARY EMBOLISM	O Yes	O No	_____	O Yes	O No
DIABETES- CONTROLLED BY DIET / INSULIN	O Yes	O No	_____	O Yes	O No
THYROID DISEASE	O Yes	O No	_____	O Yes	O No
DVT	O Yes	O No	_____	O Yes	O No
HEART DISEASE/CHEST PAIN	O Yes	O No	_____	O Yes	O No
HEART MURMER	O Yes	O No	_____	O Yes	O No
HIGH OR LOW BLOOD PRESSURE	O Yes	O No	_____	O Yes	O No
MITRAL VALVE PROLAPSE	O Yes	O No	_____	O Yes	O No
SCARLET FEVER	O Yes	O No	_____	O Yes	O No
EAR / HEARING TROUBLE- HEARING AIDS	O Yes	O No	_____	O Yes	O No
FREQUENT COLDS / SORE THROAT	O Yes	O No	_____	O Yes	O No
EPILEPSY / CONVULSIONS (SEIZURES)	O Yes	O No	_____	O Yes	O No
FREQUENT HEADACHES (MIGRAINES)	O Yes	O No	_____	O Yes	O No
MENINGITIS / BRAIN TUMOR	O Yes	O No	_____	O Yes	O No
NERVOUS BREAKDOWN	O Yes	O No	_____	O Yes	O No
EXTENSIVE WEIGHT GAIN / LOSS	O Yes	O No	_____	O Yes	O No
EYE TROUBLE- GLASSES / CONTACTS	O Yes	O No	_____	O Yes	O No
KIDNEY / BLADDER INFECTIONS	O Yes	O No	_____	O Yes	O No
RASHES / BOILS	O Yes	O No	_____	O Yes	O No
VENEREAL DISEASE / HERPES	O Yes	O No	_____	O Yes	O No

Do you have any family history of the following?..... ☐ No ☐ Diabetes ☐ High Blood Pressure ☐ Stroke ☐ Cancer ☐ Heart Disease ☐ Kidney Disease ☐ Tuberculosis ☐ Arthritis

Are you pregnant?..... ☐ Yes ☐ No

Do you use steroids?..... ☐ Yes ☐ No

Do you engage in high risk behaviors?..... ☐ Yes ☐ No

Do you drink? How much?_____ ☐ Yes ☐ No

Have you ever been a smoker? ..... ☐ Yes ☐ No

If yes... (select one please)

☐ Every day smoker

☐ Some days smoker

☐ Former smoker

☐ Occasionally

Do you chew? How much?_____

Date Completed_____