ADS ORTHOPAEDICS 11301 Fallbrook Dr., Suite 100, Houston, TX77065 * Phone: 281.807.5432 * Fax: 281.807.5437
Doan K. Nguyen, M.D

Patient's Information

Last Name:	**First Name:**	**MI**	**D.O.B.** / /
SSN: - -	**PCP:**		
Height : **Weight:** **Sex: M F**	**Advance Directive:** YES or NO	**Marital Status:** Single Married Divorced Widowed	
Race: Asian White Hispanic Black Other _____	**Ethnicity:** Spanish/Latin or Not Spanish/Latin	**Language:**	
Address:			
City:	**State:**	**Zip Code:**	
Primary Phone #	**Secondary Phone #**	**Work Phone #**	
EMAIL:	**Employer:**	**Phone #**	
Pharmacy Name, Number, and Location:			

Emergency Contact Information

Last	**First:**	**Relation:**	**Phone #:**

Insurance Information

Primary Insurance:				**Secondary Insurance:**				**Policy Holder** (If other than the patient)		
HMO	**PPO**	**POS**	**OTHER**	**HMO**	**PPO**	**POS**	**OTHER**	**First & Last Name:**		
MEMBER ID#				**MEMBER ID#**				**D.O.B:**		
GROUP #				**GROUP ID#**				**Address:**		
PHONE #				**PHONE #**				**City:**	**State:**	**ZIP:**

Description of Injury

What kind of Pain or Injury do you have?

On a scale from 1 – 10, How would you rate your pain with 1 being the lowest and 10 being the highest. (*Please Circle*) 1 2 3 4 5 6 7 8 9 10

What happened?	**Who referred you here?**
When did it happen or start?	**Where (i.e. at work, home, etc.)**

How many times have you fallen in the past 12 months? A. none B. 1 time with injury C. 2 or 3 times D. 4 or more times

Medical History

Please List current Medications (not including vitamins):

Medication Allergy/Intolerant (Allergy to drug):

Surgical History:

Social History: *(Please circle the following)*
Smoking?: Non-smoker; current smoking : every day or ____ number cigarettes/packs ____ day/week/month; former smoker - when did you quit? ____
Drinking? Heavy; moderate; occasional; does not drink

Family Disease History:

Check the following diseases or condition that apply to you

Abnormal Bleeding/Hemophilia		Cancer _____		Hepatitis (circle): A B C		Latex or Nickel Allergy	
Anemia		Cholesterol: H or L		Herpes/Fever Blisters		Nervous Disorders	
Arthritis – Area: _____		Diabetes		HIV/AIDS		Thyroid: Hyper or Hypo	
Asthma		Epilepsy/Seizures		Hypertension		Tonsils/Adenoids removed	
Blood Pressure (circle): H L		Fainting or Dizziness		Joint replacement/ Implant		Tuberculosis	
Bone Disorders		Heart Defect, Murmur		Kidney Problems		Tumor – Area _____	

Please enter here if not listed above:

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Patient Questionnaire

Today's Date _____ Height (feet/inches) _____ Weight (pounds) _____

First Name _____ Last Name _____

Date of Birth _____ Age _____ Occupation _____ Gender: ☐ Male ☐ Female

Hand dominance? ☐ Right ☐ Left ☐ Ambidexterous

Who requested you visit us today? ☐ Doctor (name) _____ ☐ Self Referral ☐ Attorney

What is your main reason for today's visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Other _____

What body part is involved?

☐ Neck Pain radiates to:	☐ R arm ☐ L arm	Shoulder	☐ R ☐ L	Elbow	☐ R ☐ L	Hand	☐ R ☐ L	Pelvis	☐ R ☐ L	Knee	☐ R ☐ L	Foot	☐ R ☐ L
☐ Back Pain radiates to:	☐ R leg ☐ L leg	Arm	☐ R ☐ L	Wrist	☐ R ☐ L	Finger	☐ R ☐ L	Hip	☐ R ☐ L	Ankle	☐ R ☐ L	Toe	☐ R ☐ L

How long has this problem been present? _____Days _____Weeks _____Months _____Years

Check ONE of the four situations below that best describes <u>how your problem started.</u> Then use the "Comments" space below to describe how it happened.

☐ **1. No Injury** Onset was: ☐ Gradual ☐ Sudden

Why do you think it started? _____

☐ **2. Injury** (from an accident or sport, NOT work or auto related)

Date _____

Where and how did it happen? _____

What sport? _____

What school? _____

☐ **3. Injury at Work** Date _____

From: ☐ Lift ☐ Twist ☐ Bend ☐ Pull ☐ Fall

☐ **4. Auto Accident** Date _____

How was the car hit? _____

Comments _____

Have you ever had a bone density scan? ☐ Yes ☐ No

If yes, where and when? _____

On a scale of 0-10 how severe is your pain? *(Please circle ONLY ONE number)*

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No Pain ⟷ Moderate Pain ⟷ Severe Pain

Please check the box in each category that best describes you problems.

Quality of pain? ☐ Sharp ☐ Dull ☐ Aching ☐ Stabbing ☐ Throbbing ☐ Burning

Timing of pain? ☐ Constant ☐ Comes and Goes Does it wake you at night? ☐ Yes ☐ No

Do you have any of the following?

☐ Swelling ☐ Bruise ☐ Loss of motion ☐ Instability ☐ Locking/Catching ☐ Grinding

☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of bowel or bladder control

Since the problem started, is the problem: ☐ Getting Better ☐ Getting Worse ☐ Unchanged

What makes your symptoms worse? *(check all that apply)*

☐ Standing ☐ Walking ☐ Lifting ☐ Reaching ☐ Exercise ☐ Twisting ☐ Lying in Bed ☐ Bending

☐ Stairs ☐ Squatting ☐ Kneeling ☐ Sitting ☐ Coughing ☐ Sneezing ☐ Other _____

What makes it better? ☐ Rest ☐ Ice ☐ Elevation ☐ Other _____

What medications have you taken for this problem? _____

What treatments have you tried? ☐ Injection ☐ Brace ☐ Physical Therapy ☐ Cane/Crutch

What tests have you had? ☐ X-Rays ☐ MRI ☐ Cat Scan (CT) ☐ Bone Scan ☐ Nerve Test (EMG/NCV)

Have you been to the Emergency Room for this problem? ☐ Yes ☐ No Which ER and when? _____

Have you already had surgery for this problem? ☐ Yes ☐ No Surgeon's name _____ Date _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

I hereby authorize the attending physician and the medical staff to perform medical procedures.
I authorize the release of any medical information necessary for the processing of insurance.
I authorize the release of any medical information necessary to the physician to whom I have referred.
A photocopy of the assignment is to be considered as valid as an original.
We cannot accept the responsibility of negotiating a settlement in a disputed claim.
YOU ARE RESPONSIBLE FOR PAYMENT ON YOUR ACCOUNT.
I have read the above statement and agree to abide by the financial policies described above.
I am providing information to the best of my knowledge.

Signature: _____ Date: _____

FINANCIAL AGREEMENT

Welcome to our office. Please take a moment to review our financial policy.

Although Dr. Nguyen accepts most insurance plans, it is the responsibility of the patient to be familiar with his or her benefits. Some procedures, x-rays, injections, and medical supplies distributed from our office may not be covered. Our office will make every attempt to verify insurance benefits prior to your visit. In the event that your insurance does not cover these services, or if benefits or eligibility is unobtainable, you will be responsible for any charges incurred.

ATTENTION HMO/MEDICAID PATIENTS: In order for your insurance to consider any medical services provided by our office, it is your responsibility to have an active referral from your primary care provider on file. In the event that there is not an active referral on file, we request that payment be made at the time of service.

Payment is due at the time of service; this will include any deductibles, office visit co-pays, and coinsurance amounts due.
We only accept cash and credit cards.
Thank you for choosing Dr. Nguyen for your healthcare needs. Please be assured that our staff will answer any questions you may have regarding our office policies.

I,_____ , HAVE READ AND DO AGREE TO THE TERMS REGARDING THIS FINANCIAL AGREEMENT.

SIGNED:_____ PRINT NAME:_____ DATE:_____

(If other than patient) Please state your RELATIONSHIP TO PATIENT:_____

PATIENT AUTHORIZATION FOR ACCESS TO PROTECTED HEALTH INFORMATION

I give permission for the following people to have access to my protected health information and reserve the right to revoke this at any time by notifying the office.
___ Any Family Member

___ Specific Family Member: Name(s) / Relationship: 1) _____

2) _____

___Other (Friend / Caregiver) Name(s) / Relationship: 1) _____

2)_____

I would like to have messages regarding: ___ Appointments, ___ Test Results

Be given to me by: Home Phone:_____ Work Phone:_____ Cell Phone:_____ Fax:_____

SIGNED:_____ PRINT NAME:_____ DATE:_____

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PAIN MANAGEMENT POLICY

For a patient with serious chronic pain, the ongoing prescription of pain medications (narcotic pain medications or other controlled substances) may be an effective way to control pain and improve quality of life. For those patients who require long-term pain medications, the following "rules" will apply:

1. Dr. Doan Nguyen must be the only physician to prescribe the patient these prescriptions. Other physicians should not prescribe the same or similar medications.
2. *If it is necessary in an emergency or other unusual circumstance* to obtain pain medication from a physician other than Dr. Nguyen, the patient must notify Dr. Nguyen's office of the circumstances on the next business day.
3. Pain medication will be prescribed in fixed amounts and with a fixed number of refills (if applicable). The patient is responsible for keeping the medications secure and for using the medications according to the instructions. It may be dangerous to take the medication other than the way it was instructed by the physician. If you are taking any medications for any other health reasons, please be sure to contact your pharmacist for any questions about medication interactions.
4. When the patient is due for a refill, the patient is responsible for making an appointment with Dr. Nguyen. The patient should make his/her appointment at least one week prior to the prescription running out.
5. *Except under unusual circumstances*, Dr. Nguyen will not refill medications early.
6. If the patient feels a change in medication is needed, he/she should make an appointment with Dr. Nguyen to discuss/review the concern. Under normal circumstances, medication changes will not be made over the phone.
7. It is the patient's responsibility to make other physicians and health care providers aware of the medications they are taking. *Failure to do so may result in serious complications.*
8. In many instances, long-term pain medications must be slowly decreased (tapered) to prevent withdrawal symptoms/reactions. Please discuss any desire to stop these medications with Dr. Nguyen.
9. The patient should use one pharmacy for all pain medication prescriptions. Using one pharmacy will allow continuity of care and medication oversight for yourself and Dr. Nguyen.
10. Dr. Nguyen may require, *without advance notice*, the patient submit a drug screen during the course of a visit.
11. Prescriptions are to only be used as prescribed and to the patient it was prescribed to. Unauthorized distribution of prescription medication such as sharing or selling medication is illegal and behavior that is not tolerated by Dr. Doan Nguyen.

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PAIN MANAGEMENT POLICY (cont'd)

Failure of the patient to comply with the above rules may result in dismissal from Dr. Nguyen's practice. Other reasons for dismissal may include:

1. Falsifying or forging prescriptions.
2. Obtaining pain medications from different physicians without notification.
3. Excessive use of Emergency Room of After Hours Clinic for pain-related problems.
4. Unacceptable behavior may include missing appointments, abusive language, unreasonable demands, and making threats.
5. Unauthorized distribution of medication, such as sharing or selling medication.
6. Failure to comply with Dr. Nguyen's pain management treatment regimen.
7. Use of illegal or non-therapeutic drugs.

By signing, I understand and agree to comply with the Pain Management Policy of ADS Orthopaedics.

_____ _____
Signature of Patient Date

_____
Patient's Printed Name

_____ _____
Signature of Physician Date

_____ _____
Signature of Witness Date