THE FONG INSTITUTE

Brian L. Fong, M.D. & Christopher Scott Grow, PA-C

NEW PATIENT PACKET

(Please Print)

Patient Name:_____ Date:_____

Age:_____ □ M □F Occupation:_____ Dominant Hand: □ R □ L

Height:_____ Weight:_____ Blood Pressure:_____ BMI:_____

Who is your Primary Care Physician?_____
Who referred you here?_____ □Doctor □ Family/Friend □ Self
□ Attorney □ Other_____
What insurance do you have? _____

1. What is the chief complaint/main reason for visit today?

□ Pain □ Stiffness □ Unstable/Dislocated Joint
□Numbness □ Swelling □ Other_____
□Weakness □Fracture/Broken Bone

2. A) Location: What *body part* is involved?_____
B) □ Right □Left □Both

3. Duration: How long has the problem been present? _____

4. How did the problem start? □gradual □sudden

A) No injury
Why do you think the problem started?_____
B) Injury at work (Date of injury_____)
From □ lift □twist □ bend □ pull □reach □ other_____
C) Work related
How did your job cause this problem?_____
D) Sports injury (Date of injury_____)
Please explain_____
E) Auto Accident (Date_____)
Please describe accident _____
□ driver □ passenger □seatbelt Y/N □airbag Y/N
F) Other (e.g. fall, direct blow, etc.)
Please explain_____

5. What is your level of pain? □none □mild □moderate □severe

6. Please describe the quality of pain □ sharp □dull □throbbing □aching □burning □other

7. Since this problem has started, it is: □improving □ worsening □unchanged

8. Does your pain wake you at night? □yes □no

9. Is your pain: □constant □comes and goes

10. Do you have: □swelling □bruising □numbness □tingling □weakness
□bladder or bowel dysfunction □ giving out □ stiffness
□locking □popping/clicking

11. Do you have: □nothing □standing □walking □running □stairs □exercise
□squatting □ kneeling □lifting □twisting □bending
□ lying in bed □sitting □coughing □sneezing □throwing
□overhead activity □grabbing
□repetitive motion (describe)_____
□other_____

12. What helps the problem? □rest □heat □ice □elevation □brace/splint □medicine
□nothing □other_____

13. Please list medications you have taken for this problem:_____

14. Have you had this problem previously? □yes □no when?_____

15. What previous treatment has been tried? (please provide any detail and dates)

□none	**□injection_____**
□bracing	**□Physical therapy_____**
□crutches	**□previous medicine_____**
□cane	**□Surgery_____**
	□Chiropractic_____
	□other_____

16. Where you seen in the ER or an after hour clinic for this problem?
□no □yes where?_____ Date:_____

17. What tests have you had for this problem?
□none □x-ray □MRI □CT scan □nerve test (EMG/NCV) □bone scan
□ultrasound □other_____

18. Are you pregnant or could be pregnant? □no □yes

Office use only

___f/u	___DME	___PT	___MRI/CT	___work stat.
___med	___cast/splint	___HEP	___Surg.	___c/s
___inj.	___ice	___EMG/NCS	___other	

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ACKNOWLEGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I, individually or on behalf of the patient, hereby acknowledge and agree that I have received a copy of The Fong Institute's Notice of Privacy Information Practices.

_____ Signature

_____ Patient's legal representative (if applicable)

_____ Date

Official use only

The Fong Institute has made good faith efforts to attain the above referenced acknowledgement of receipt of the Notice of Privacy Information Practices but is unable to obtain the acknowledgement of receipt. The reason(s) are as follows:

_____

_____

PERMISSION TO DISCLOSE RELEVANT HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN MY HEALTH CARE

___ I give permission for The Fong Institute to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below who are involved in my health care.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

___ I give permission for The Fong Institute to leave a message on my answering machine.

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(Please Print Legibly- Medical Records Data)

Patient's Name: (Last First Middle)	Date of Birth	Age	Marital Status S M W D SEP	Sex M F	Social Security No.
Street address:	City and state			Zip code	Home phone:
Patients Employer:	Occupation (indicate if student)			How Long	Work phone:
Drug Allergies:					Cell phone:
Referred By:	Primary Care Physician:				
Spouse name:	Employer				Work #
Father's Name	Employer				Work #
Mother's Name	Employer				Work #
Person to Notify incase of Emergency	Relationship				Work/Home #
Date of Injury:	Was an Automobile involved?	Where you injured on the job?			Employer at time of injury:
Were x-rays taken of this problem? Yes No	Where?				Date X-rays were taken:
Party Responsible for payment:	DOB / /	Address, Street, City, Zip code			Phone #
Primary Insurance Company	Policy Holders Name				Social Security No.
Other Insurance Company	Policy Holders Name				Social Security No.
OFFICE USE ONLY					

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize The Fong Institute to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. In understand that I am responsible for any amount not covered by insurance.

NOTICE OF DISCLOSURE OF OWNERSHIP INTEREST

Certain physician members of Fong Institute have an ownership interest in Southern Surgical Hospital. These physicians have become owners as a result of their commitment to quality health care to assure proper service to their patients. I understand that my physician may have an ownership interest in a facility to which I may be referred and that I have the right to obtain medical services at a facility of my choice.

Date:_____ **Signature:**_____

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MEDICAL HISTORY QUESTIONNAIRE

(Please Print)

Past Medical History (please check all that apply)

	Illness/Injury		Illness/Injury
	High Blood Pressure		Asthma
	Diabetes		Lung disease (specify)
	Heart Attack		Kidney disease (specify)
	Heart Problems (specify)		Liver disease (specify)
	Ulcers, stomach or intestinal		Pervious anesthesia problems
	Stroke		Thyroid Problems
	Cancer (specify)		Blood Clots/DVT's
	Hepatitis		Bleeding tendency
	HIV/AIDS		Osteoporosis
	Arthritis		Females: Are or could you be pregnant
	Rheumatologic disease		
	Gout		Other:

Past Surgical History (please list previous surgeries)

#	Date:	Type of Operation	Complications/Problems
1			
2			
3			
4			
5			
6			
7			
8			

Please List any current medications

Drug	Dosage and Frequency	Drug	Dosage and Frequency
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Do you take blood thinners? □yes □no
Do you have drug allergies? □yes □no

If yes to allergies, please list

Drug	Reaction	Drug	Reaction
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Please list any other allergies (e.g. egg, iodine, latex) _____

Doctor's Notes:

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Social History

Do you use tobacco? □no □yes	if yes, # of packs/day____ #of years____
Do you use e-cigs? □no □yes	If yes, how many times a day?_____
Do you drink alcoholic beverages? □no □yes	If yes, what type and how often?_____
Have you recently quit smoking? □no □yes	If yes, when did you quit?_____

Family History (please check all that apply)

	Illness/injury		**Illness/injury**
	Heart Disease		Rheumatoid Arthritis
	Diabetes		Gout
	High Blood Pressure		Degenerative Arthritis
	Cancer- please specify _____		Immunologic Disorder
	Anesthesia Problem		Other:_____

Review of Systems (please check any recent problems)

	Constitutional System		**Gastrointestinal**		**Neurological**
	Recent weight changes		Loss of appetite		Frequent Headaches
	Fever		Nausea or vomiting		Light headed or dizzy
	Unexplained sweating		Frequent diarrhea		Seizures
	Eyes		Constipation		Numbness or tingling
	Wears glasses or contacts		Blood in stool or rectal bleeding		Tremors
	Blurry or double vision		Black tarry stools		Paralysis
	Glaucoma		Abdominal Pain or heart burn		**Psuchiatric**
	Ear, Nose, Throat		**Genitourinary**		Memory Loss or confusion
	Hearing loss		Frequent Urination		Anxiety
	Regular nose or gum bleeding		Burning or painful urination		Insomnia
	Sore throat		Blood in Urine		Depression
	Swollen glands in the neck		Incontinence or dribbling		**Endocrine**
	Cardiovascular		Female: # of pregnancies_____		Glandular or hormone problem
	Irregular heartbeats		Female: # of miscarriages____		Excessive thirst or urination
	Shortness of breath		**Musculoskeletal**		Heat or cold intolerance
	Chest Pain		Joint pain		Changes in hair or nails
	Swelling in feet, ankles, or hands		Joint stiffness and swelling		**Hematolology**
	Fainting spells		Morning stiffness		Bleeding or bruising tendency
	Respiratory		Difficulty walking		Anemia
	Chronic or frequent coughing		Muscle cramping		History of blood transfusion
	Spitting up blood		**Integumentary**		
	Emphysema		Rash or itching		Height_____
	Wheezing		Changes in skin color		Weight_____
			Varicose veins		

Patient Signature (or parent/guardian if patient is a minor) _____ **date**:_____

_____

Doctor:
I certify that I have reviewed the information in this form.

Doctor Signature:	**Date:**	**Doctor Signature:**	**Date:**	**Doctor Signature:**	**Date:**

Fong Institute

2965 Gause Blvd E, Suite A
Slidell, Louisiana 70461
(985) 641-7775 fax (985) 641-1166

MEDICAL RELEASE OF INFORMATION

Authorization for the Use and Disclosure of Protected Health Information

I authorize Fong Institute to:
Obtain / release medical records of: _____
(patient's full legal name)

Patient's date of birth: _____ Social Security # _____

Records to be obtained from: _____
(Name)

_____
(Street Address)

_____
(City and State)

Release to: ***Fong Institute***
2965 Gause Blvd E, Suite A
Slidell, Louisiana 70461
(985) 641-7775 fax (985) 641-1166

Include the following specific record(s):

___ Abstract pertinent _____
____ Operative reports (dates) _____
____ Lab reports (dates) _____
____ Radiology reports (dates) _____
____ Clinic Notes (dates) _____
____ Other _____

___***I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Fong Institute. I understand that the revocation will not apply to my insurance company for services already rendered.***
___***The information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and no longer protected.***
___ ***Fees/charges will comply with all laws and regulations applicable to release of information.***
___ ***I understand authorizing the use or disclosure of the information identified above is voluntary. I do not need to sign this form to ensure healthcare treatment.***

I have read the above and authorize the disclosure of the protected health information as stated.

Signature: _____
(Signed Patient, Parent or Guardian)

Witness: _____***DATE***: _____

_____

CONFIDENTIALITY NOTICE: The document accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

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PAIN MANAGEMENT AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

I understand that if I break this Agreement, my doctor will stop prescribing these pain control medicines.

In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug –dependency treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my life, and how well the medicine is helping to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines controlled stimulants, or anti-anxiety medicines form any other doctor.

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will NOT be replaced.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evening or on weekends.

I agree to use _____Pharmacy, located at _____, telephone number _____, for filling prescriptions for all my pain medicine.

I authorize the doctor any my pharmacy to cooperate fully with the city, state, or federal law enforcement agency, including this state's board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my Pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test if requested by my physician to determine my compliance with my program of pain control medicine.

I agree that I will use my medicine at a rate no greater than that prescribe rate and that of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused pain medication to every office visit.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been answered. A copy of the document has been given to me.

This Agreement is entered into on_____, _____, 20_____.

Patient Signature_____

Physician Signature _____.