ROOM #

FONG INSTITUTE

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

NEW PATIENT PACKET

Patient Name: ________________________ Date: ___________________

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

OFFICE USE ONLY	**Height: _______**	**Weight: _______**	**BMI: _____________**
	Blood Pressure: ___________	**Pulse: ________**	**Temp: _________**

Who is your Primary Care Physician? ______________________
Who referred you here? ____________________ □Doctor □ Family/Friend □ Self □ Attorney

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? ____________________

Doctors Notes:

Office use only

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

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 trouble: □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. Were you seen in the ER or an urgent care 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

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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		Previous anesthesia problems
	Stroke		Thyroid Problems
	Cancer: specify		Blood Clots/DVT's
	Hepatitis		Bleeding tendency
	HIV/AIDS		Osteoporosis
	Arthritis		
	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, vitamins, and supplements

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) ____

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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		**Psychiatric**
	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		**Hematology**
	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		
	Wheezing		Changes in skin color		
			Varicose veins		

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

____

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(Please Print Legibly- Medical Records Data)

<table>
<tr><td>Patient's Name:
(Last First Middle)</td><td>Date of Birth</td><td></td><td>Marital Status
S M W D SEP</td><td>Sex
M
F</td><td colspan="2">Social Security No.</td></tr>
<tr><td>Street address:</td><td colspan="3">City and state</td><td colspan="2">Zip code</td><td>Home phone:</td></tr>
<tr><td>Patients Employer:</td><td colspan="3">Work phone:</td><td colspan="2"></td><td>Cell phone:</td></tr>
<tr><td>Spouse name:</td><td colspan="5">Employer</td><td>Work #</td></tr>
<tr><td>Father's Name (If pt is minor)</td><td colspan="5">Employer</td><td>Work #</td></tr>
<tr><td>Mother's Name (If pt is a minor)</td><td colspan="5">Employer</td><td>Work #</td></tr>
<tr><td>Person to Notify in case of Emergency</td><td colspan="5">Relationship</td><td>Work/Home #</td></tr>
<tr><td>Party Responsible for payment:</td><td>DOB
/ /</td><td colspan="4">Address, Street, City, Zip code</td><td>Phone #</td></tr>
<tr><td>Primary Insurance Company</td><td colspan="4">Policy Holders Name</td><td colspan="2">Social Security No.</td></tr>
<tr><td>Other Insurance Company</td><td colspan="4">Policy Holders Name</td><td colspan="2">Social Security No.</td></tr>
<tr><td>Do you have Medicaid as a secondary</td><td colspan="4">YES or NO Initial:</td><td colspan="2"></td></tr>
</table>

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize 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. I 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 because 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.

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.

Date: ___________________ Signature: _____________________________

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

___ I give permission for 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: ______________________

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

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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Phone: (985)641-7775 Fax: (985)641-1166

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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 prescribed. Any rate greater than prescribed 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 my questions and concerns regarding treatment have been answered. A copy of the document has been given to me.

This Agreement is entered on_______________________, ___________, 20______.

Patient Signature_____________________________________