Physician Name: Michael G. Kaldis, M.D.

PATIENT DEMOGRAPHIC INFORMATION SHEET

Last Name | First Name | Middle | Social Security No.

Date of Birth | Age | Gender | Marital Status: M S W D *(Please circle one)*

Home Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Contact Preference: *(Please Check One)* Home Work Cell Mail Email Address

Referred By: Phone #:

EMERGENCY CONTACT INFORMATION

Name | Phone No. | Alt. Phone | Relationship

PATIENT EMPLOYER INFORMATION

Employer Name | Phone | Fax

Address | City | State | Zip

GUARANTOR / POLICY HOLDER INFORMATION

Last Name | First Name | Middle | Social Security No.

Date of Birth | Patient's Relationship to Policy Holder | Home Phone | Cell Phone

Employer Name | Phone | Fax

Employer Address | City | State | Zip

INSURANCE INFORMATION

Primary Insurance — Name of Primary Insurance | ID/Policy Number | Group Number | Customer Service No.

Secondary Insurance — Name of Secondary Insurance | ID/Policy Number | Group Number | Customer Service No.

Work Comp Insurance — Name of WC Insurance | Claim # | Adjuster Name | Adjuster Phone No.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT RELEASE ME FROM MY PERSONAL RESPONSIBILITY FOR PAYMENT OF ALL CHARGES WITHIN 50 DAYS. AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OF TREATMENT.

Signature: Date:

Southwest Orthopedic Group, L.L.P.
Michael G. Kaldis, M.D.

Patient Form
CERVICAL SPINE/SHOULDER

Name_____ Age_____ Sex_____

Date of Evaluation_____ Height _____ Weight _____

Referred by _____

List all medications you are currently taking (including vitamins, or herbs), or attach a list:

_____ _____ _____

_____ _____ _____

Drug Allergies _____Yes _____No (*if yes, please list)*

_____ _____ _____

Date of injury (if involved in accident) _____Auto accident _____On the job

Name of Employer (if work related)?_____

Occupational/Physical Requirements?_____

Name of Attorney involved in case?_____

Mechanism of injury:

1)Twisting	_____Yes _____No
2) Lifting	_____Yes _____No
3) Fall	_____Yes _____No
4) Blunt Trauma	_____Yes _____No
5) Motor Vehicle Accident	_____Yes _____No
6) Other _____	

Chief Complaint:

Neck pain only	_____Yes _____No
Arm pain only	_____Right_____Left _____Both
Neck & arm pain	_____Right_____Left _____Both

When did neck pain begin? Month _____ Day _____ Year 20 _____

Character of neck pain:
_____Dull ache
_____Sharp/stabbing
_____Shooting
_____Other_____
_____

Frequency of neck pain:
_____Intermittent
_____Constant
_____Other_____

Do you have radiation of pain into arms? ____ Yes _____No (*If yes, which arm)* _____Right _____Left _____Both

Frequency: _____Constant _____Intermittent

_____Upper Arm _____Elbow _____Forearm _____Wrist _____Hand _____Fingers

Numbness: _____Yes _____No (If yes, which arm) _____Right _____Left_____Both

Frequency _____Constant _____Intermittent

Location (Specify right/left/both as L/R/B below)
_____Upper Arm _____Elbow _____Forearm _____Wrist _____Hand _____Fingers

$[[FN]] *$[[PID]]*

Tingling: _____Yes _____No _____Right _____Left _____Both

Frequency of tingling _____Constant _____Intermittent

_____Upper Arm _____Elbow _____Forearm _____Wrist _____Hand _____Fingers

What makes pain better
_____Nothing
_____Medication
_____Heat
_____Ice
_____Exercise
Other_____
_____

What makes pain wore
_____Nothing
_____Lifting
_____Reaching
_____Driving
_____Other_____ _____
_____
_____

Past medical history
_____High blood pressure
_____Heart disease
_____Diabetes
_____Cancer
_____Other_____
_____

Previous surgeries:
_____
_____
_____
_____

Social History
_____Smoker _____packs per day
_____drugs
_____Alcohol _____rarely _____occasionally ____heavy

Family History ____ Heart disease ____Diabetes ____ Cancer ____ Strokes

Review of systems
Do you know or have you had problems related to the following systems?

GU
____Trouble with urination
____Frequent urination
____Blood in urine

NEURO/PSYCH
____Headache
____Depression

ENT/PULMONARY
____Sore throat
____Cough
____Trouble breathing
____Chest pain

OTHER
_____Fever _____°F
_____Chills

GI
____Abdominal pain
____Nausea
____Vomiting
____Diarrhea
____Black/bloody stool

SKIN
____Skin rash

Have you had recent physical therapy? _____Yes _____No

Frequency/duration: _____x per week for _____weeks/months

_____Hot packs
_____Massage
_____Ultrasound
_____Neck exercise
_____Other_____
_____

Improvement with physical therapy:
_____None
_____Some
_____Moderate
_____Very good

PHYSICAL EXAMINATION OF THE CERVICAL SPINE/SHOULDER
(for office use only)

APPARENT DISTRESS: Alert & oriented ( ) None ( ) Mild ( ) Moderate ( ) Severe ( )

GENERAL BODY HABITUS: Thin ( ) Obese ( ) Muscular ( )

UPPER EXTREMITIES

PASSIVE RANGE OF MOTION SHOULDER	Right/left
Flexion	WNL
Extension	WNL
Abduction	WNL
Adduction	WNL
Internal rotation	WNL
External rotation	WNL

SHOULDER Impingement Test Positive - Negative | Tinels Test Positive - Negative | Phalens Test Positive - Negative

TENDERNESS: Shoulder - right/left/both
None ( ) Mild ( ) Moderate ( ) Severe ( )

MUSCLE STRENGTH TESTING	RIGHT	LEFT
Biceps	5/5	5/5
Triceps	5/5	5/5
Deltoids	5/5	5/5
Wrist extensors	5/5	5/5
Hand Intrinsics	5/5	5/5

CERVICAL SPINE
DEFORMITY: None ( ) Scoliosis ( ) Mild ( ) Severe ( )

ACTIVE RANGE OF MOTION:
None ( ) Mild ( ) Moderate ( ) Severe ( )

TENDERNESS: Neck Paraspinous Musculature - right/ left/ both
None ( ) Mild ( ) Moderate ( ) Severe ( )

NEUROLOGICAL

DEEP TENDON REFLEXES	RIGHT	LEFT
Biceps	+2	+2
Triceps	+2	+2

ATROPHY:

IMPRESSION:
Arthritis, shoulder 716.91
Degenerative Disc/cervical 722.4
Extruded Disc/cervical 722.71
Fracture cervical/compression/closed - 805.0
HNP- cervical 722.0
Impingement syndrome 726.19
Myofascial pain syndrome 729.1
Neuropathy, ulnar 354.2
Neck pain 723.1
Carpal Tunnel Syndrome 354.0
Cervical Spondylosis 721.0
Cervical Radiculopathy 723.4
Shoulder Pain 719.41
Cervical strain 847.0

PATIENT NAME: _____

SOUTHWEST ORTHOPEDIC GROUP, LLP

Review of Notice of Privacy Practices

Acknowledgement:

I acknowledge that I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Patient or Personal Representative **Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____.

Financial Policy Statement

It is the policy of Southwest Orthopedic Group, LLP, to bill your insurance carrier as a courtesy to you; however, you are responsible for the entire bill. We require that arrangements for payment of your estimated share be made today. The insured/patient is responsible for any co-payments at the time service is rendered. If your insurance carrier does not remit payment within sixty (60) days, the balance will be due in full from you. If your insurance pays in excess of the balance of your account, we will refund the credit.

If any payment is made directly to you for services billed by Southwest Orthopedic Group, LLP, you recognize an obligation to promptly remit payment to Southwest Orthopedic Group, L.L.P.

The above does not apply to those patients that are considered Workers' Compensation. However, be advised as a Workers' Compensation patient that you may be held responsible for your charges in the event that your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Southwest Orthopedic Group, LLP, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

_____ _____

Responsible Party Print Name **Date**

_____

Responsible Party Signature