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

Thoracic And/Or Lumbosacral Spine

Name_____ Age_____Sex_____ Height _____ Weight _____

Date of Evaluation_____ Referred by _____

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

_____ _____ _____

Drug Allergies _____No _____Yes **(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?_____

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:

Lower back pain _____Yes _____No
Leg pain only _____Right_____Left _____Both
Low back & leg pain _____Right_____Left _____Both

Is the pain/problem constant or intermittent, and how long does it last (be specific)?

_____

When did Lower Back pain begin? Month _____ Day _____ Year 20 _____

Character of back pain:
_____None
_____Dull ache
_____Sharp/stabbing
_____Shooting
_____Other_____

Frequency of back pain:
_____None
_____Intermittent
_____Constant
_____Other_____
_____

When did leg pain begin? _____

Does pain radiate into leg(s)? ____ Yes _____No **Which leg?**_____Right_____Left_____Both

Frequency: _____Constant_____Intermittent

Location: (Specify right/left/both as L/R/B below)

_____Buttock____Thigh_____Calf_____Foot_____Toes

<u>Numbness:</u> _____Yes _____No _____Right _____Left_____Both

Frequency _____Constant _____Intermittent
Location (Specify right/left/both as L/R/B below)

_____Buttock _____Thigh _____Calf _____Foot _____Toes

<u>Weakness:</u> _____Yes _____No _____Right _____Left _____Both
Frequency _____Constant _____Intermittent

Location (Specify right/left/both as L/R/B below)
_____Buttock_____Thigh_____Calf_____Foot_____Toes

Any loss of bowel or bladder control? _____Yes _____No *(Please explain)*

_____

Tingling? _____Yes _____No _____Right _____Left _____Both

Frequency of tingling _____Constant _____Intermittent

Location (Specify right/left/both as L/R/B below)

_____Buttock _____Thigh _____Calf _____Foot _____Toes

What makes pain better:
_____Nothing
_____Medication
_____Heat
_____Ice
_____Exercise
_____Other_____

What makes pain worse:
_____Nothing
_____Lifting
_____Bending
_____Stooping
_____Standing
_____Walking
_____Sitting
_____Climbing Stairs
_____Coughing
_____Sneezing
_____Riding in an mobile

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
____Nause
____Vomiting
____Diarrhea
____Black/bloody stool

SKIN
____Skin rash

Past Medical and Social History

Past medical history:
_____Peptic ulcer disease
_____Heart disease
_____Compression fracture
_____Intervertebral disc disease
_____Arthritis
_____Other_____
____High blood pressure
_____Diabetes (Insulin, oral, diet)
_____Cancer
_____Prior back pain/injury
_____Sciatica

Previous Surgeries and dates:
_____None
_____Back Laminectomy Fusion discectomy
_____Other _____ _____ _____

Social History:
_____Smoker _____packs per day
_____drugs
_____Alcohol _____rarely _____occasionally ____heavy

Family History: ____ Heart disease ____Diabetes ____ Cancer ____ Strokes

Recent physical therapy?_____Yes_____No

Frequency/duration: _____x per week for _____weeks/months
_____Hot packs
_____Massage
_____Ultrasound
_____Other_____

Improvement with physical therapy:
_____None _____Moderate
_____Some _____Very good

THORACIC / LUMBAR PHYSICAL EXAM

APPARENT DISTRESS: Alert & oriented ( ) Mild ( ) Moderate ( ) Severe ( )

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

LOWER EXTREMITIES

PASSIVE RANGE OF MOTION	Hip	Knee	Ankle
	Right/left	Right/left	Right/left
Flexion	WNL	WNL	WNL
Extension	WNL	WNL	WNL
Abduction	WNL		
Adduction	WNL		
Internal rotation	WNL		
External rotation	WNL		

PULSES

Dorsalis pedis pulse	Present	Absent
Posterior tibial	Present	Absent

MUSCLE STRENGTH TESTING	RIGHT	LEFT
Iliopsoas	5/5	5/5
Quadriceps	5/5	5/5
Hamstrings	5/5	5/5
Gastrocnemius	5/5	5/5
Anterior tibialis	5/5	5/5
Extensor hallucis longus	5/5	5/5

SPINE

SURGICAL SCAR: Midline Iliac None

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

ACTIVE RANGE OF MOTION: Limitation of flexion and lateral bending
None ( ) Mild ( ) Moderate ( ) Severe ( )

TENDERNESS:

Sciatic Notch - right/left/both
None ( ) Mild ( ) Moderate ( ) Severe ( )

Paraspinous Musculature
Thoracic - right/left/both
None ( ) Mild ( ) Moderate ( ) Severe ( )

Paraspinous Musculature
Lumbar - right/ left/ both
None ( ) Mild ( ) Moderate ( ) Severe ( )

ATROPHY:

SITTING ROOT TEST:

Right - Negative ( ) Positive ( ) Equivocal ( )
Left - Negative ( ) Positive ( ) Equivocal ( )

STRAIGHT LEG LIFT TEST:

Right - Negative ( ) Positive ( ) Equivocal ( )
Left - Negative ( ) Positive ( ) Equivocal ( )

NEUROLOGICAL

DEEP TENDON REFLEXES	RIGHT	LEFT
Patellar tendon	+2	+2
Achilles's tendon	+2	+2
Babinski	Negative	Negative
Ankle clonus	Absent	Absent
Discriminatie touch	Intact	Intact
Proprioception	Intact	Intact

HEEL WALK: WNL ( ) Weakness on right ( ) Weakness on left ( )

TOE WALK: WNL ( ) Weakness on right ( ) Weakness on left ( )

IMPRESSION AND PLAN:

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