MICHAEL O. LAGRONE, M.D., P.A. | ORTHOPAEDIC SURGERY
Adult & Pediatric Spine Surgery – Scoliosis – Pediatric Orthopaedics
1600 Coulter, Building B, Amarillo, Texas 79106
Phone: (806) 354-2529 | Fax: (806) 354-2956 | www.scoliosismd.com

PATIENT INFORMATION

Name: ______________________ **DOB**: ____________ **SS#**: ______________

Address:______________________ **City**: ____________ **State**:________ **Zip**:__________

Home Phone:________________ **Work Phone**: ________________ **Cell Phone**:________________

Email Address:______________________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced **Sex**: ☐ Male ☐ Female **Age**: ________

IF PATIENT IS A MINOR, Parent(s) or Legal Guardian Name: ______________________

How did you hear about Michael O. LaGrone, MD, PA: ☐ **Referral** ______________________

☐ **Friends/Family:** ______________________ ☐ **Other:** ______________________

INSURANCE INFORMATION

A copy of your insurance card(s) is required prior to your appointment.

Primary Insurance	**Secondary Insurance**
Insurance Company: ______________	Insurance Company: ______________
Address: ______________	Address: ______________
Phone: ______________	Phone: ______________
Subscriber Name:______________	Subscriber Name: ______________
Subscriber Employer:______________	Subscriber Employer:______________
Relationship to Patient: ______________	Relationship to Patient: ______________
Subscriber DOB: ______________	Subscriber DOB: ______________
Subscriber SS#: ______________	Subscriber SS#: ______________
ID #: ______________	ID #: ______________
Group #:______________	Group #: ______________
Referral #: ______________ *(If Applicable)*	Referral #: ______________ *(If Applicable)*

Is this visit related to any type of on the job, motor vehicle, or third party accident? ☐ Yes ☐ No

If so, what kind of accident? ______________________ **Date of accident**: ______________

I hereby authorize the release of requested medical information and/or records to my primary care physician, insurance company, third party review organization, peer review physician, employer or their representatives. I understand that I am responsible for all charges not paid by my insurance company, subject to any contractual limitations between my physician and insurance company or managed care network. I understand that I am responsible for promptly responding to my insurance company to provide any additional information they may request regarding my treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in my account becoming due and payable, in full, immediately. I will be prepared to present my insurance card and proof of identity (e.g. driver's license) at each visit. I will provide a change of address, telephone number and / or insurance information any time a change occurs.

______________________________________ ______________

Signature of Patient, Parent, or Legal Guardian Date

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PATIENT CONSENT TO TREATMENT

I hereby authorize Michael O. LaGrone, M.D. to render medical evaluations and care to the patient indicated below. I further consent to the performance of any diagnostic procedures, examinations and rending of medical treatments by Michael O. LaGrone, M.D. or his designee as is necessary in the medical staff's judgment. I understand that the practice of medicine and surgery is not an exact science and acknowledges that no guarantee have been or will be made regarding the results of examinations or treatments in this clinic.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

____
Patient Name (please print)

____ ____________________
Signature of Patient, Parent, or Legal Guardian Date

FINANCIAL POLICY

We are committed to providing you with the best possible care. Since payment of your bill is part of your treatment, we want you to be sure that our financial policies are clearly understood before we begin treatment.

We participate with most insurance plans, but it is your responsibility to call your insurance company to determine whether or not we participate with your particular plan. Please be prepared to provide your insurance card at every visit. Also, tell us if there is a change in your address, telephone number, or insurance coverage at the time of your visit. If your coverage has been terminated prior to your visit with our office, you are responsible for all of the charges incurred. All co-payments and fees are due when services are rendered. We cannot waive your co-payment, as this is an agreement between you and your insurance company. It is your responsibility to know your insurance policy requirements, such as co-payments and deductibles. We will not become involved in disputes between you and your insurance company regarding deductibles or co-payments. This office only files claims with contracted insurance carriers up to three (3) times. If your insurance company has not paid in full, the balance due may become your responsibility. If overpayment occurs, we will credit your account and you may request a refund, as long as there are no other balances owed.

There will be a $25.00 no-show charge to all patients who do not give 24-hour notice of cancellation. Insurance companies do not cover this charge. If you do not show or do not cancel, this fee will be your responsibility. Anyone with a no-show fee must pay on or before your next visit in order to see one of our providers.

We accept cash, checks, Visa, MasterCard, Discover and American Express.

I have read, understand, and agree to the above financial policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility. I understand that it is my responsibility to contact my insurance carrier(s) if they do not respond to payment requests made on my behalf.

____ ____________________
Signature of Patient, Parent, or Legal Guardian Date

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PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e., narcotics, tranquilizers and barbiturates) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state and federal governments. They are intended to relieve pain, thus improving function and/or ability to work. Our providers are dedicated to restoring functional use in an efficient and functional manner.

You are responsible for the controlled substance medications prescribed to you. This includes safeguarding the medication from other family members and ensuring it is out of the reach of children. If your prescription is lost, misplaced, stolen or if you "run out early", please understand that medication will not be replaced. Refills will not be made if you "run out early", "lose a prescription", or "spill or misplace" your medication. You are responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.

Driving a motor vehicle may not be allowed while taking controlled substance medications and it is your responsibility to comply with the laws of the state while taking the prescribed medications.

Refills of controlled substance medications will only be made only during regular office hours, Monday through Friday. Refills will not be made at night, on weekends, or during holidays. Refills will not be made as an "emergency" such as on Friday afternoon because you suddenly realize you will run out tomorrow. You must call at least 24 hours ahead if you need assistance with a refill.

Michael O. LaGrone, M.D. is not a chronic pain specialists. Narcotic medications are prescribed only for acute pain or for post-surgical pain and then only for a limited time. If you require long-term narcotic medication, you will be referred to or consult with a pain specialist or your primary care physician.

If you violate any of the above conditions, your prescription for controlled substance medications may be terminated immediately. If you are involved in obtaining controlled substance medications from another individual, forging or altering a controlled substance prescription, or using non-prescribed illicit (illegal) drugs, your prescription for controlled substance medications will be terminated immediately and you may also be reported to all of your physicians, medical facilities, and appropriate authorities.

All prescriptions for controlled substance are to be filled at the same pharmacy (provided below) by only one physician. You are required to notify our office of any changes.

Pharmacy: ______________________________ Phone: ____________________

I have read this contract and I fully understand the consequences of violating this agreement.

____
Patient Name (please print)

______________________________________ ____________________
Signature of Patient, Parent, or Legal Guardian Date

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

By signing below, you acknowledge that you have received the attached *Notice of Privacy Practices* prior to any service being provided to you by the office of Michael O. LaGrone, M.D, P.A., and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

____

____

Patient Name: ____________________________ Patient Date of Birth: __________________
(Please Print Name)

SIGNATURES:

Patient/Legal Representative: ________________________________ Date: __________________

If Legal Representative, relationship to Patient: ______________________________________

PATIENT PERMISSION FOR RECORD DISCLOSURE

I hereby give permission to Michael O. LaGrone, M.D., P.A. to disclose and discuss any information related to my medical and financial condition(s) to/with the following:

Name	Relationship to Patient/Date of Birth	Phone Number

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

____ __________________
Signature of Patient, Parent or Legal Guardian Date

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NEW PATIENT/NEW COMPLAINT HISTORY FORM

Please take the time to answer all questions that apply to your problem as completely as possible.

Date: ________________ Referring Doctor/Primary Doctor: ______________________________

Name: ____ Age: ______________

Main Complaint: ____

Date of injury or onset of pain: __________ Gradual onset: _________ Sudden Onset: _________

Have you had similar problems in the past? If so, when? ______________________________

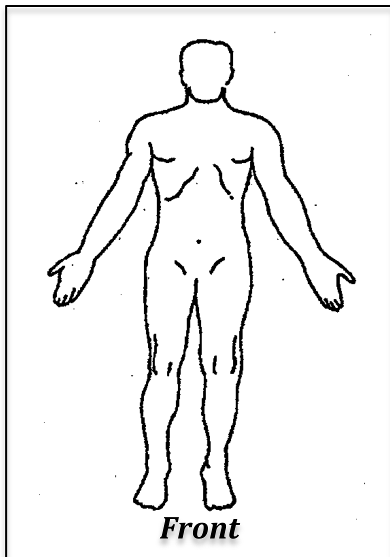
Have you had a spine surgery in the past? If so, when? ______________________________

Are you working? ☐ Yes ☐ No If no, when was your last day? ______________________________
Is this an on-the-job injury? ☐ Yes ☐ No Was this injury caused by a motor vehicle accident? ☐ Yes ☐ No

Was this injury caused by a fall? ☐ Yes ☐ No When? ________________ Where? ________________

USING THE SYMBOLS BELOW, MARK DRAWING ACCORDING TO YOUR PAIN. INCLUDE ALL AFFECTED AREAS.

ache/sore: >>>
cramping: ccc
dull: DDD
pressure: ppp
burning: BBB
sharp: sss
tingling: xxx
shooting +++
throbbing: TTT
pins/needles: ooo
numb: nnn
stabbing: ///



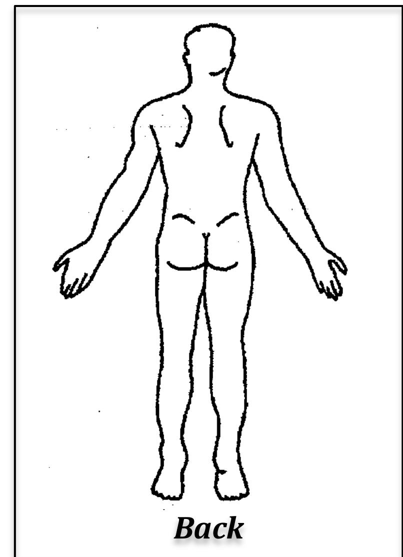
Neck Pain: Circle Severity Level
0 1 2 3 4 5 6 7 8 9 10
minor moderate severe

Pain in arm(s) compared to neck:
☐ Worse than ☐ Same as ☐ Less than

Upper Back Pain: Circle Severity
0 1 2 3 4 5 6 7 8 9 10
minor moderate severe

Low Back Pain: Circle Severity Level
0 1 2 3 4 5 6 7 8 9 10
minor moderate severe

Pain in leg(s) compared to back:
☐ Worse than ☐ Same as ☐ Less than



Check/Circle/Highlight Any That Apply

ARE YOU GETTING:
☐ Better
☐ Worse
☐ Unchanged

ARE YOU USUALLY IN:
☐ Mild discomfort
☐ Moderate discomfort
☐ Severe discomfort

PAIN IS WORSE IN THE:
☐ Morning (6am – 12pm)
☐ Afternoon (1pm-8pm)
☐ Night (8pm – 6am)

DOES PAIN COME ON:
☐ Suddenly
☐ Gradually

PAIN IS:
☐ Constant
☐ Good & bad days

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Which increases your pain or discomfort? Please indicate any or all that apply.

- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Bending Forward
- ☐ Bending Backward

- ☐ Lying on back
- ☐ Lying on side
- ☐ Lying on stomach
- ☐ Rising from sitting

- ☐ Coughing
- ☐ Sneezing
- ☐ Urination
- ☐ Bowel Movement
- ☐ Sexual activity

- ☐ Menses/Periods
- ☐ Other____________________

What is the approximate time you can perform the following activities?

Sit: __________ minutes Stand:________minutes Walk:________minutes

Do you use a device to help you get around? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: __________

Which decreases your pain or discomfort? Please indicate any or all that apply.

- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Bending Forward
- ☐ Bending Backward

- ☐ Lying on back
- ☐ Lying on side
- ☐ Lying on stomach
- ☐ Rising from sitting

- ☐ Coughing
- ☐ Sneezing
- ☐ Urination
- ☐ Bowel Movement
- ☐ Sexual activity

- ☐ Menses/Periods
- ☐ Other____________________

Conservative Treatments:

Physical/Occupational Therapy:	Date:________	☐ No Relief	☐ Moderate Relief	☐ Excellent Relief
Heat/Ice:	Date:________	☐ No Relief	☐ Moderate Relief	☐ Excellent Relief
Traction:	Date:________	☐ No Relief	☐ Moderate Relief	☐ Excellent Relief
TENS:	Date:________	☐ No Relief	☐ Moderate Relief	☐ Excellent Relief
Ultrasound:	Date:________	☐ No Relief	☐ Moderate Relief	☐ Excellent Relief
Massage:	Date:________	☐ No Relief	☐ Moderate Relief	☐ Excellent Relief
Brace or Collar:	Date:________	☐ No Relief	☐ Moderate Relief	☐ Excellent Relief
Psychotherapy:	Date:________	☐ No Relief	☐ Moderate Relief	☐ Excellent Relief
Chiropractic:	Date:________	☐ No Relief	☐ Moderate Relief	☐ Excellent Relief
Injections (Back and Neck Only):	Date:________	☐ No Relief	☐ Moderate Relief	☐ Excellent Relief

Who is your pain management Doctor? ______________________________

Other:________________	Date:________	☐ No Relief	☐ Moderate Relief	☐ Excellent Relief

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Present and Past Medical History:

Heart Disease:

- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation
- ☐ Mitral/Aortic Valve Problems
- ☐ Other: ______________________
- ☐ M.I./Heart Attack? When?______________________
- ☐ Pacemaker/Defibrillator
- ☐ Hypertension (High Blood Pressure)
- ☐ High Cholesterol
- ☐ Stroke/TIA, When? __________

Pulmonary:

- ☐ Asthma
- ☐ COPD
- ☐ Pulmonary Hypertension
- ☐ Other: ______________________

Diabetes:

- ☐ Insulin Dependent
- ☐ Non-Insulin Dependent
- ☐ Diabetic Neuropathy

Thyroid Problem:

- ☐ Type:________________________

Renal/Kidney Disease:

- ☐ Type:________________________

Gastrointestinal:

- ☐ GERD/Reflux
- ☐ Irritable Bowl
- ☐ Ulcers
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Other:_______________

Hepatitis/Liver Disease:

- ☐ Type:________________________

Bleeding Disorders:

- ☐ Type:________________________
- ☐ Blood Clots (DVT, Pulmonary Embolus)

Cancer:

- ☐ Type:________________________
  Where:_________________
  When:_________________

Other:

- ☐ Gout
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Depression/Anxiety
- ☐ Other:

Review of Systems:

Constitutional: ☐ Night Sweats ☐ Fever/Chills ☐ Weight Loss/Gain______lbs in last year ☐ None

Eyes: ☐ Visual changes ☐ Glasses ☐ Contacts ☐ None

Ears Nose Throat: ☐ Hearing Problems ☐ Sore Throat ☐ Cold ☐ Sinus Allergies ☐ None

Cardiovascular: ☐ Chest Pain ☐ Palpitations ☐ Leg Swelling ☐ Calf Cramping with Walking ☐ None

Respiratory: ☐ Short of Breath ☐ Wheezing ☐ Frequent Cough ☐ Coughing up Blood ☐ None

Gastrointestinal: ☐ Ulcer ☐ Bowl/Bladder Control Problem ☐ Diarrhea ☐ Vomiting ☐ None

Genitourinary: ☐ Incontinence ☐ Burning while Urinating ☐ Blood in Urine ☐ Kidney Stones ☐ None

Sexual Function: ☐ Impotence ☐ Painful Intercourse ☐ Not Sexually Active ☐ None

Musculoskeletal: ☐ Backache ☐ Joint Stiffness ☐ Joint Swelling ☐ Joint Pain ☐ None

Integumentary: ☐ Rash ☐ Hair problem ☐ Nail problem ☐ None

Neurological: ☐ Headaches ☐ Fainting ☐ Memory Loss ☐ Tingling/Numbness ☐ None

Psychiatric: ☐ Depression ☐ Nervousness ☐ Personality Change ☐ Previous Psychiatric Care ☐ None

Endocrine: ☐ Excessive Urination ☐ Excessive Thirst ☐ Intolerance to Heat or Cold ☐ None

Hematologic/Lymphatic: ☐ Abnormal Bleeding ☐ Anemia ☐ None

Allergic/Immunological: ☐ Immunization Problems ☐ Allergy Shots ☐ None

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NEW PATIENT/NEW COMPLAINT HISTORY FORM

Prior Surgeries: (what, when and name of surgeon)

____
____
____

Allergies: (Drugs, Foods, Environmental) □ NO KNOWN ALLERGIES
□ Latex □ Penicillin □ Keflex □ Sulfa Type Drugs □ Other types of Antibiotics______________
□ Anti-Inflammatories □ Aspirin □ Codeine □ Morphine □ Hydrocodone □ Other Medication
□ Anesthetics/History of Malignant Hyperthermia including family members______________________________

List all of your medications and vitamins/supplements: (you may provide a separate list if necessary)

____
____
____

Family Medical History:
Mother: □ Alive □ Deceased, at what age__________due to____
Father: □ Alive □ Deceased, at what age__________due to____
Number of siblings living _________________number of siblings deceased______________

Family Members (Parents, siblings, grandparents, aunts and uncles) **suffer the following**:
□ Stroke □ Diabetes □ Lung Disease □ High Blood Pressure □ Heart Trouble □ Back problems
□ Cancer □ Osteoporosis □ Scoliosis □ Kyphosis □ Arthritis □ None □ Unknown
□ Other:__________________________________

Social History: □ Single □ Married □ Separated □ Divorced □ Widowed

Education: □ Grammar School □ High School □ College □ Post-Graduate

Smoking: □ Yes □ No If yes how long?__________years Have you quit smoking? □ Yes □ No When?________________

How many packs per day?_________________________ How long did you smoke before quitting?__________ years
Do you chew or dip tobacco? □ Yes □ No If Yes, How much?______________________________________

Alcohol: □ Yes □ No If yes, what type and how much per day?____

Do you use any type of recreational drug? □ Yes □ No If yes, what type and how frequent?________________________

Have you ever been to rehab, for alcohol or drug abuse? **?** □ Yes □ No If Yes, When?_____________________________

Recreational Activities, exercise, hobbies:

□ Running □ Walking □ Treadmill □ Elliptical Machine □ Cycling, □ Golf, □ Yoga/Pilates
□ Weightlifting □ Aerobic Class □ Other: ____

List all of your treating Doctors

____
____
____