

**PATIENT MEDICAL HISTORY**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_ PAST PCP: \_\_\_\_\_

CARDIOLOGIST: \_\_\_\_\_ PULMONOLOGIST: \_\_\_\_\_

RHEUMATOLOGIST: \_\_\_\_\_ PAIN MANAGEMENT: \_\_\_\_\_

DATE OF LAST MENSTRUAL CYCLE: \_\_\_\_\_ (FEMALE ONLY)      LAST MAMMOGRAM: \_\_\_\_\_ (FEMALE ONLY)

**CHIEF COMPLAINT**

WHY ARE YOU SEEING THE DOCTOR TODAY? \_\_\_\_\_

HAVE YOU HAD TREATMENT FOR THIS PROBLEM BEFORE?     YES     NO

DATE SYMPTOMS BEGAN: \_\_\_\_\_

WHICH HAND IS YOUR DOMINATE HAND?     RIGHT     LEFT

DO YOU EXERCISE/PLAY SPORTS?             YES     NO

ARE YOU/COULD YOU BE PREGNANT?         YES     NO

**PAST MEDICAL HISTORY** PLEASE CHECK ANY/ALL OF THE FOLLOWING THAT APPLY

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> ANEMIA            | <input type="checkbox"/> DEPRESSION      | <input type="checkbox"/> HIGH BLOOD PRESSURE      | <input type="checkbox"/> PERIPHERAL VASCULAR DISEASE |
| <input type="checkbox"/> ARTHRITIS TYPE:   | <input type="checkbox"/> DIABETES        | <input type="checkbox"/> HIGH CHOLESTEROL         | <input type="checkbox"/> PULMONARY EMBOLISM          |
| <input type="checkbox"/> ASTHMA            | <input type="checkbox"/> DVT/BLOOD CLOTS | <input type="checkbox"/> IRRITABLE BOWEL SYNDROME | <input type="checkbox"/> STROKE/TIA                  |
| <input type="checkbox"/> BLADDER PROBLEMS  | <input type="checkbox"/> EPILEPSY        | <input type="checkbox"/> KIDNEY ISSUES            | <input type="checkbox"/> TUBERCULOSIS                |
| <input type="checkbox"/> BLEEDING/BRUISING | <input type="checkbox"/> GOUT            | <input type="checkbox"/> LIVER DISEASE            | <input type="checkbox"/> THYROID PROBLEM             |
| <input type="checkbox"/> CANCER TYPE:      | <input type="checkbox"/> HEART DISEASE   | <input type="checkbox"/> LUNG PROBLEMS            | <input type="checkbox"/> OTHER: _____                |
| <input type="checkbox"/> HEART DISEASE     | <input type="checkbox"/> HEPATITIS       | <input type="checkbox"/> MRSA/STAPH INFECTION     | _____  |
| <input type="checkbox"/> COPD/EMPHYSEMA    | <input type="checkbox"/> HIV/AIDS        | <input type="checkbox"/> OSTEOPOROSIS             | _____  |

**MEDICATION HISTORY** LIST ALL MEDICATIONS YOU TAKE **WITH OR WITHOUT** A PRESCRIPTION

**PHARMACY NAME:** \_\_\_\_\_ **PHONE NUMBER:** \_\_\_\_\_

**PHARMACY ADDRESS:** \_\_\_\_\_

NAME OF MEDICATION	DOSAGE	REASON FOR TAKING
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**ALLERGIES** PLEASE DESCRIBE ANY CURRENT OR PAST ALLERGIC REACTIONS

DRUG ALLERGY	REACTION

I HAVE NO ALLERGIES

**PAST SURGICAL HISTORY**

PROCEDURE	HOSPITAL	YEAR

I HAVE NOT HAD SURGERY OR BEEN HOSPITALIZED

**SOCIAL HISTORY**

DO YOU SMOKE/VAPE?  YES  NO      HAVE YOU SMOKED/VAPED IN THE PAST?  YES  NO

HOW LONG? \_\_\_\_\_ # PACKS A DAY: \_\_\_\_\_ BRAND: \_\_\_\_\_

DO YOU DRINK ALCOHOL?  YES  NO      HOW MANY DRINKS A MONTH? \_\_\_\_\_

DO YOU HAVE A HISTORY OF DRUG/ALCOHOL ABUSE?  YES  NO

**FAMILY HISTORY** CHECK BOX IF A BLOOD RELATIVE HAS BEEN DIAGNOSED WITH THE FOLLOWING

	MOTHER	FATHER	SIBLING	(M) GRANDMOTHER	(M) GRANDFATHER	(F) GRANDMOTHER	(F) GRANDFATHER
<b>ALZHEIMER'S</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ARTHRITIS</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CANCER</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>DIABETES</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>GOUT</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>HEART DISEASE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>OSTEOPOROSIS</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>STROKE</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>SUDDEN DEATH</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>OTHER</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**REVIEW OF SYSTEMS** CHECK ANY/ALL YOU HAVE EXPERIENCED IN THE PAST MONTH

GENERAL	RESPIRATORY	EYES	ENDOCRINE
<input type="checkbox"/> FEVER/CHILLS	<input type="checkbox"/> SHORTNESS OF BREATH	<input type="checkbox"/> GLASSES/CONTACTS	<input type="checkbox"/> PAINFUL URINATION
<input type="checkbox"/> WEIGHT CHANGE	<input type="checkbox"/> COUGH	<input type="checkbox"/> CATARACTS	<input type="checkbox"/> FREQUENT URINATION
<input type="checkbox"/> HORMONE PROBLEMS	<input type="checkbox"/> WHEEZING	<input type="checkbox"/> GLAUCOMA	<input type="checkbox"/> INCONTINENCE
HEMATOLOGIC/LYMPHATIC	NEUROLOGICAL	PSYCHOLOGICAL	CARDIOVASCULAR
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> ANXIETY	<input type="checkbox"/> CHEST PAIN
<input type="checkbox"/> TENDENCY TO BRUISE	<input type="checkbox"/> NUMBNESS/TINGLING	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> PALPITATIONS
<input type="checkbox"/> CLOTTING DISORDER	<input type="checkbox"/> SEIZURES	<input type="checkbox"/> INSOMNIA	<input type="checkbox"/> EXTREMITY FLUID/SWELLING
<input type="checkbox"/> SWOLLEN LYMPH NODES	<input type="checkbox"/> WEAKNESS	<input type="checkbox"/> MOOD SWINGS	<input type="checkbox"/> SYNCOPE
ENT/MOUTH	SKIN	GASTROINTESTINAL	
<input type="checkbox"/> SORE THROAT	<input type="checkbox"/> RASHES	<input type="checkbox"/> ABDOMINAL PAIN	<input type="checkbox"/> DIARRHEA
<input type="checkbox"/> EAR PAIN	<input type="checkbox"/> LUMPS	<input type="checkbox"/> HEARTBURN/ACID RELIEF	<input type="checkbox"/> NAUSEA
<input type="checkbox"/> NASAL CONGESTION	<input type="checkbox"/> ITCHING/PURITIS	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> VOMITING
<input type="checkbox"/> HARD OF HEARING	<input type="checkbox"/> OTHER:		

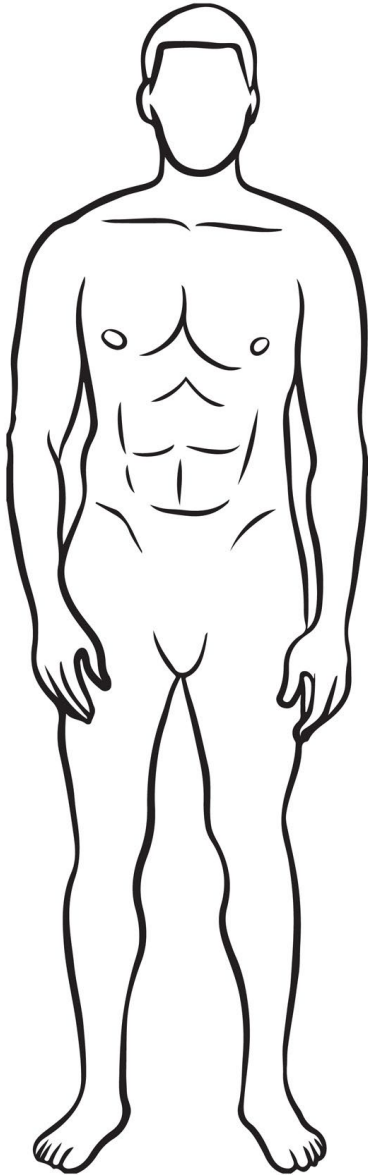
NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

PLEASE MARK AN "X" ON THE BODY PART(S) WHERE YOU HAVE PAIN, AN "0" ON THE BODY PART(S) WHERE YOU HAVE NUMBNESS.

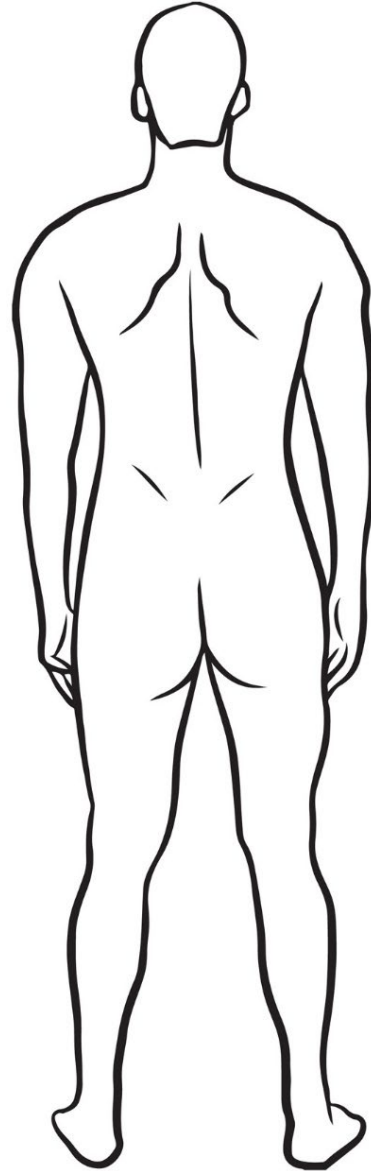
**LEFT**

**RIGHT**



**LEFT**

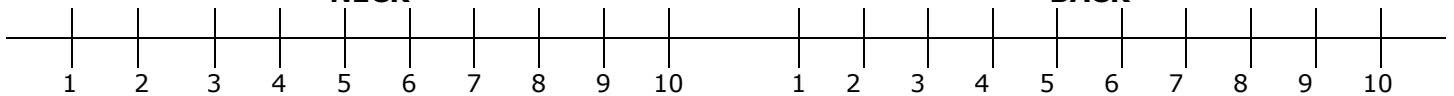
**RIGHT**



**SELECT A NUMBER TO INDICATE TYPICAL LEVEL OF PAIN**

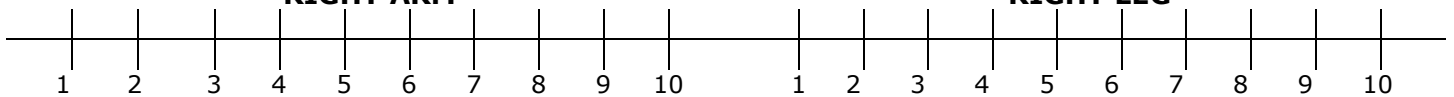
**NECK**

**BACK**



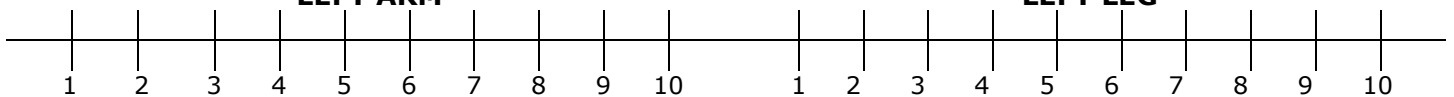
**RIGHT ARM**

**RIGHT LEG**



**LEFT ARM**

**LEFT LEG**



**PATIENT INFORMATION**

NAME: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
 SS NUMBER: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ GENDER: \_\_\_\_\_  
 EMAIL ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
 EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 RELATIONSHIP TO PATIENT: \_\_\_\_\_

**FOR MEDICARE PATIENTS ONLY:** DO YOU LIVE IN A SKILLED NURSING FACILITY?  YES  NO

IF YES, WHAT IS THE NAME OF THE FACILITY? \_\_\_\_\_

**EMPLOYMENT/STUDENT STATUS**

EMPLOYED FULL TIME     STUDENT FULL TIME    EMPLOYER NAME AND ADDRESS: \_\_\_\_\_  
 EMPLOYED PART TIME     STUDENT PART TIME \_\_\_\_\_  
 UNEMPLOYED \_\_\_\_\_  
 RETIRED    OCCUPATION: \_\_\_\_\_

**ETHNICITY OF PATIENT:**

HISPANIC ORIGIN  
 NON-HISPANIC ORIGIN  
 UNKNOWN  
 DECLINED TO ANSWER

**RACE OF PATIENT:**

AMERICAN INDIAN/ ALASKAN NATIVE  
 ASIAN  
 BLACK/ AFRICAN AMERICAN  
 NATIVE HAWAIIAN/ OTHER PACIFIC ISLANDER  
 WHITE  
 UNKNOWN  
 DECLINED TO ANSWER

**PREFERRED LANGUAGE:**

ENGLISH     SPANISH  
 OTHER: \_\_\_\_\_

**MARITAL STATUS:**  SINGLE     MARRIED     OTHER: \_\_\_\_\_

TO DEMONSTRATE MEANINGFUL USE, WE ARE REQUIRED TO CAPTURE DEMOGRAPHIC DATA, INCLUDING YOUR PREFERRED LANGUAGE, RACE, AND ETHNICITY, IN COMPLIANCE WITH THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 (ARRA).

**FINANCIALLY RESPONSIBLE PERSON (IF DIFFERENT FROM ABOVE)**

NAME: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
 SS NUMBER: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
 EMPLOYER NAME: \_\_\_\_\_  
 RELATIONSHIP TO PATIENT: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**INSURANCE COMPANY INFORMATION**

PRIMARY INSURANCE COMPANY NAME: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

SECONDARY INSURANCE COMPANY NAME: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

PLEASE CHECK THIS BOX IF YOU WILL NOT BE USING AN INSURANCE COMPANY FOR TREATMENT.

**INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS**

I CERTIFY THAT THE INFORMATION I REPORTED ABOUT MY INSURANCE COVERAGE IS CORRECT. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO AVALA FOR ANESTHESIA AND ORTHOPEDIC SURGICAL SERVICES PROVIDED TO ME. I FULLY UNDERSTAND THAT PAYMENT FOR SERVICES IS NOT CONTINGENT UPON RECOVERY, AND THIS DOES NOT RELIEVE ME OF MY PRIMARY OBLIGATION TO PAY.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**MEDICARE PATIENTS**

IF YOU ARE COVERED BY MEDICARE, PLEASE READ AND SIGN THE FOLLOWING:  
IN MEDICARE CASES, AVALA AGREES TO ACCEPT THE CHARGE DETERMINATION OF MEDICARE AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR DEDUCTIBLE, CO-INSURANCE, AND NON-COVERED SERVICES. COINSURANCE AND DEDUCTIBLES ARE BASED UPON THE CHARGE DETERMINATION OF MEDICARE.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**E-PRESCRIBING**

E-PRESCRIBING IS A FEDERALLY MANDATED INITIATIVE THAT REQUIRES ALL PHYSICIANS PRESCRIBE IN THIS MANNER BY 2011.

E-PRESCRIBING SOFTWARE SENDS PRESCRIPTIONS OVER THE INTERNET TO YOUR PHARMACY IN A SAFE, SECURE WAY THROUGH THE SAME TECHNOLOGY USED BY CREDIT CARD COMPANIES. THIS HELPS PROTECT THE PRIVACY OF YOUR PERSONAL INFORMATION.

EPRESCRIBING SOFTWARE ALSO LETS YOUR DOCTOR SEE IMPORTANT INFORMATION - LIKE DRUG INTERACTIONS AND YOUR PRESCRIPTION HISTORY.

**PATIENT CONSENT**

I AGREE THAT AVALA MAY REQUEST AND USE MY PRESCRIPTION MEDICATION HISTORY FROM OTHER HEALTHCARE PROVIDERS OR THIRD-PARTY PHARMACY BENEFIT PAYORS FOR TREATMENT PURPOSES.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

**DESIGNATION OF INDIVIDUAL INVOLVED IN MY CARE**

UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA"), YOU HAVE THE RIGHT TO AUTHORIZE THE RELEASE OF YOUR PROTECTED HEALTH INFORMATION, INCLUDING MEDICAL AND BILLING RECORDS, TO AN INDIVIDUAL(S) YOU DESIGNATE. PLEASE COMPLETE THIS FORM IN ITS ENTIRETY, DESIGNATING THE INDIVIDUAL(S) WITH WHOM YOU WOULD LIKE AVALA TO SHARE YOUR INFORMATION.

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**DESIGNATION OF INDIVIDUAL(S) INVOLVED IN MY CARE:**

AT MY REQUEST, I HEREBY IDENTIFY THE FOLLOWING INDIVIDUAL(S):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(COLLECTIVELY, THE "DESIGNATED INDIVIDUAL") AS AN INDIVIDUAL(S) INVOLVED IN MY CARE, I HEREBY AUTHORIZE AVALA TO RELEASE ANY AND ALL PROTECTED HEALTH INFORMATION ABOUT ME, INCLUDING BILLING AND MEDICAL RECORDS, TO THE DESIGNATED INDIVIDUAL. THIS AUTHORIZATION PERMITS THE DISCLOSURE OF PAPER RECORDS, ELECTRONIC RECORDS, AND VERBAL COMMUNICATIONS. ADDITIONALLY, TO THE EXTENT MY MEDICAL OR BILLING RECORDS CONTAIN INFORMATION RELATED TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC CARE, SEXUALLY TRANSMITTED DISEASE, HEPATITIS B OR C TESTING, HIV/AIDS, AND/OR OTHER SENSITIVE INFORMATION, I HEREBY AGREE TO ITS RELEASE

**TERMINATION/REVOCAION OF DESIGNATION:** UNLESS TERMINATED SOONER IN WRITING BY ME, THIS AUTHORIZATION WILL TERMINATE THREE (3) YEARS AFTER MY LAST DATE OF TREATMENT BY AVALA. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AND CANCEL THIS DESIGNATION BY SENDING A WRITTEN REVOCATION OF DESIGNATION FORM TO AVALA. I UNDERSTAND AND ACKNOWLEDGE THAT THE REVOCATION OR CANCELLATION OF THIS DESIGNATION SHALL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED BEFORE THE REVOCATION/CANCELLATION DATE.

**RE-DISCLOSURE:** I UNDERSTAND THAT THE INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY HIPAA.

**NO OBLIGATION TO SIGN:** I UNDERSTAND I DO NOT HAVE TO SIGN THIS AUTHORIZATION, AND TREATMENT WILL NOT BE DENIED IF I DO NOT SIGN THIS FORM. I HEREBY RELEASE AND DISCHARGE AVALA, ITS EMPLOYEES, AGENTS, AND OWNERS OF ANY LIABILITY AND WILL HOLD THEM HARMLESS OR COMPLYING WITH THIS AUTHORIZATION.

**ACKNOWLEDGEMENT**

\_\_\_\_\_  
 PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_, HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES OF **AVALA**.

\_\_\_\_\_ **INITIAL**

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

**SECTION A: REQUIRED FOR ALL AUTHORIZATION FOR RELEASE OF PHI OR RIGHT OF ACCESS**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PATIENT ADDRESS: \_\_\_\_\_ SS NUMBER:(OPTIONAL) \_\_\_\_\_

PHI RECIPIENT NAME: AVALA ORTHO FAX NUMBER: 985-674-1722

PHI SENDER NAME: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_

**THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING: (FILL IN THE DATE OR EVENT, BUT NOT BOTH)**

DATES: \_\_\_\_\_ EVENT: \_\_\_\_\_

**PLEASE CHECK WHICH OF THE FOLLOWING YOU WOULD LIKE TO BE REQUESTED:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> ALL PHI IN RECORD    | <input type="checkbox"/> PHYSICIAN ORDERS  | <input type="checkbox"/> DEMOGRAPHICS            |
| <input type="checkbox"/> HISTORY AND PHYSICAL | <input type="checkbox"/> LABORATORY        | <input type="checkbox"/> REHABILITATION SERVICES |
| <input type="checkbox"/> CONSULT REPORT       | <input type="checkbox"/> IMAGING/RADIOLOGY | <input type="checkbox"/> SPECIAL TEST/THERAPY    |
| <input type="checkbox"/> OPERATIVE REPORT     | <input type="checkbox"/> NURSING NOTES     | <input type="checkbox"/> ITEMIZED BILL/CLAIMS    |
| <input type="checkbox"/> PROGRESS NOTE        | <input type="checkbox"/> MEDICATION RECORD | <input type="checkbox"/> OTHER                   |

**I ACKNOWLEDGE AND HEREBY CONSENT TO SUCH THAT THE RELEASE INFORMATION MAY CONTAIN ALCOHOL, DRUG ABUSE, OR PSYCHIATRIC. HIV TESTING, HIV RESULTS, OR AIDS INFORMATION.**

\_\_\_\_\_ **INITIAL**     IF NOT APPLICABLE, CHECK HERE

**I UNDERSTAND THAT:**

- > I MAY REFUSE TO SIGN THIS AUTHORIZATION, AND MY TREATMENT WILL NOT BE CONDITIONED UPON THE SIGNATURE OF THIS AUTHORIZATION (EXCEPT FOR NON-HEALTH-RELATED SERVICES SUCH AS PRE-EMPLOYMENT TESTING, LIFE INSURANCE EXAMS, OR DRUG SCREENINGS).
- > I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING, BUT IF I DO, IT WILL NOT HAVE ANY EFFECT ON ANY ACTIONS TAKEN BEFORE RECEIVING THE REVOCATION. FURTHER DETAILS MAY BE FOUND IN THE NOTICE OF PRIVACY PRACTICES.
- > IF THE REQUESTOR OR RECEIVER IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL REGULATIONS AND MAY BE RE-DISCLOSED.
- > I UNDERSTAND THAT I MAY SEE AND OBTAIN A COPY OF THE INFORMATION DESCRIBED ON THIS FORM FOR A REASONABLE COPY FEE IF I ASK FOR IT.
- > I WILL RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.

**SECTION C: SIGNATURES**

I HAVE READ THE ABOVE AND AUTHORIZE THE DISCLOSURE OF THE PROTECTED HEALTH INFORMATION.

\_\_\_\_\_  
 PATIENT/GUARDIAN/PATIENT REPRESENTATIVE SIGNATURE \_\_\_\_\_  
DATE

\_\_\_\_\_  
 PRINT NAME OF PATIENT'S REPRESENTATIVE: \_\_\_\_\_  
RELATIONSHIP TO THE PATIENT

**PLEASE MAIL MEDICAL RECORDS TO AVALA ORTHO AT  
 1200 PINNACLE PARKWAY, COVINGTON, LA, 70433, OR FAX RECORDS TO 985-674-1722.**

**ACCIDENT QUESTIONNAIRE**

PATIENT: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

INSURED'S NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

WERE YOU INJURED IN A MOTOR VEHICLE ACCIDENT?       YES       NO

DID YOUR INJURY TAKE PLACE WHILE YOU WERE WORKING?       YES       NO

OTHER? \_\_\_\_\_

DATE OF ACCIDENT/INJURY: \_\_\_\_\_

LENGTH OF PAIN OR PROBLEM: \_\_\_\_\_

WHERE/WHEN/HOW? \_\_\_\_\_

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE