Barry J. Henry, M.D., A.P.M.C.

Family Orthopaedic Surgery and Sports Medicine Specialist

Patient's Name: _____
LAST *FIRST* *MIDDLE*

Preferred Name: _____ DOB: _____

SS#: (Optional) _____ Sex: (Circle One) Male / Female Race: _____

Physical Address: _____

Billing Address: _____

Home Phone #: _____ Cell #:_____ Work #:_____

Contact Preference: (Circle One) Home / Cell / Work Email: _____

Emergency Contact Name: _____ Phone: _____

Nearest Relative /Friend Not Living with You: _____Phone:_____

Marital Status: (Circle One) Married / Single / Divorced / Separated / Widowed / Partner

Patients Condition Related to: (Circle One) Employment / Auto Accident / Other Accident / None

Patient's Employer: _____ Employer Phone:_____

Employer Address: _____ Patient's Occupation: _____

Attorney Name: _____ Phone: _____

How did you hear about us? _____

Pharmacy Preferred: _____
NAME *LOCATION* *PHONE NUMBER*

IF PATIENT IS A DEPENDENT

Father's Name: _____ Employer: _____

Occupation: _____Employer Phone: _____

Mother's Name: ____ Employer: _____

Occupation: _____Employer Phone: _____

IF YOU WERE INJURED AT WORK

Employer at time of injury: _____ Employer Phone: _____

Employer address: _____

Date of onset injury or accident: _____ Claim Number: _____

INSURANCE

Primary Ins. Company: _____ Secondary Ins. Company_____

Identification # _____Identification #_____

Group# _____Group #_____

Insured Name: _____ Insured Name: _____

Insured DOB: _____Insured DOB: _____

1. **Individuals Authorized to Discuss My Medical Information**

   The individuals listed below have my permission to obtain and/or discuss my personal medical information.

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

2. **Permission to Leave Appointment Messages**

   My signature below indicates my permission for Dr. Barry J. Henry and /or his staff to leave a recorded or verbal message regarding the date, time, and location of my scheduled Appointment(s).

3. **Financial Responsibility**

   As a courtesy to you, we will bill your insurance company for services provided. **All co-payments, co -insurance and unsatisfied deductibles must be paid at the time of service.** I understand that I am ultimately responsible for all fees regardless of insurance coverage. I agree to pay the amount due in full at the time of service. I agree to pay any collection and/attorney fees that are added to the unpaid balance. **Interest may also be added to any lien or account past due 120 days and over.**

4. **No Show Fee**

   I understand that any scheduled appointment must be canceled or rescheduled within 8 hours of the appointment time. Our 24 hour answering service is able to take your call. Failure to comply will result in a No Show Fee of $20.00 which will be due at your next appointment.

5. **Authorization to Release Information Needed to Process Insurance Claims**

   I authorize Barry J Henry M.D., A.P.M.C. to release any medical information necessary to process insurance claims.

6. **Assignment of Insurance Benefits**

   I hereby authorize payment for medical and surgical benefits to go to Barry J Henry, M.D., A.P.M.C.

7. **Prescription Restrictions**

   I understand that prescription are not written or called in on Fridays.

8. **Acknowledgement of Receipt of Privacy Notice Effective September 17, 2011**

   I have been presented with a copy of Barry J, Henry M.D., A.P.M.C.'s Notice of Privacy Policies, detailing how my health information may be used, and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal health information.

   _____

   _____

9. **Permission to receive email**

   My signature below indicates that I give permission for Dr. Henry's office to email me as needed. You may contact us at any time to remove yourself from our list.

My signature below indicates I have read, understand, and agree with all of the above stated information.

Signed: _____ Date: _____

Barry J. Henry, M.D.

401 N. College Rd, Lafayette LA, 70506

Patient: _____ DOB: _____ Chart #: _____

FAMILY PHYSICIAN: _____

CURRENT MEDICATIONS

Please list all medications you are currently taking.
Including: Aleve, Aspirin, Advil, Tylenol, Vitamins, etc.
Name and Strength

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES

Do you have any known drug or solution allergies?
If yes, please describe your allergic reaction to the drug or solution.

☐ No Known Drug Allergies
☐ Penicillin Reaction: _____
☐ Sulfa Drug Reaction: _____
☐ Codeine Reaction: _____
☐ Aspirin Reaction: _____
☐ Alcohol Wipes Reaction: _____
☐ Betadine Reaction: _____
☐ Other: _____ Reaction: _____

CURRENT MEDICAL PROBLEMS:

☐ No Current Medical Problems
☐ Diabetes
☐ Liver Disease
☐ Stomach Ulcers
☐ Gout
☐ Cancer
☐ High Cholesterol
☐ MRSA
☐ Other: _____
☐ High Blood Pressure
☐ Heart Disease
☐ Lung Disease
☐ Bleeding Disorder
☐ Kidney Disease
☐ Arthritis
☐ Pacemaker

SOCIAL HISTORY

Alcohol Use: ☐ Never ☐ <2/week ☐ 1-2/day ☐ >2/day
Tobacco Use: ☐ Never ☐ In Past ☐ Presently ☐ pk/day
Illegal Drugs: ☐ Never ☐ Yes: _____

Patient's Signature and Date

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Barry J. Henry, M.D.
401 N. College Rd, Lafayette LA, 70506

PATIENT'S MEDICAL HISTORY

Date_____

Chart Number _____

Patient's Name: _____ **Age:** _____**D.O.B:** _____ **Sex:** _____

MEDICAL HISTORY

Do you now have, or have you ever had any of the following?

	NO	YES
Stroke	☐	☐
Heart Trouble	☐	☐
High Blood Pressure	☐	☐
Diabetes	☐	☐
Arthritis	☐	☐
Gout	☐	☐
Kidney Problems	☐	☐
Cancer	☐	☐
Bleeding Disorder	☐	☐
Blood Clots	☐	☐
Stomach Ulcers	☐	☐
Liver Disease	☐	☐
Lung Disease	☐	☐
Other Major Medical Illness	☐	☐

PREVIOUS SURGERIES

Please list all surgical procedures you have had in the past.

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Is there any significant Family History you would like us to know about?

_____

_____

_____

_____

_____

_____

SEE BACK SIDE OF PAGE FOR MORE QUESTIONS

Date _____
Chart # _____

SOCIAL HISTORY
Please answer the following questions.

Most Recent Occupation: _____

Current Work Status: ◯ Employed Full-time ◯ Employed Part-time ◯ Unemployed
◯ Retired ◯ Student ◯ Disabled

Do you exercise regularly? ☐ No
☐ Yes, type of exercise_____, hours per week _____

What are your hobbies? _____
_____

Marital Status: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Do you presently live alone? ☐ No ☐ Yes

OPTIONAL: Have you ever been tested for AIDS ☐ No ☐ Yes, results_____
Do you consider yourself at risk for HIV or AIDS? ☐ No ☐ Yes

Patient Signature _____ Date _____
(My signature states that the above stated information is correct to the best of my knowledge.)

For Office Use Only

Initials_____ ***Date*** _____