Information Packet
for your visit with
Donald A. Lakatosh, M.D.

Dear Client:

In an effort to make you more at ease on your visit in the office, we have enclosed a packet of forms for you to complete and return in the enclosed, postage paid envelope to our Knoxville, Tennessee office. Please do not return this paperwork to the Aiken, SC office as we are only there on a limited basis. We will contact you to schedule your impairment rating.

- Please make sure you bring your department of energy card, driver's license or other photo ID, as we will need to make a photocopy of each one. We will not be able to see you without a photo ID.

- You may need to bring your medications with you to the appointment.

If you need to re-schedule or have any questions, please feel free to contact this office at **(865) 577-1914.** You may find more information about Dr. Lakatosh and his practice by visiting **www.DrLakatosh.com.**

Best regards,

Donald A. Lakatosh, M.D. and Staff

Note New Address:

151 Linden Street, SW
Aiken, SC 29801

PATIENT INFORMATION

Registration Form

Last Name: _____ **First Name:** _____ **Middle Initial**: _____

Address: _____ **City:** _____ **State:** ____ **Zip Code:** _____

Home Phone: (____) _____-_____**Work Phone:** (____)_____-_____ **Cell:** (____)_____-_____

Marital Status: S / M / D / W **Sex:** M / F **Race:** Caucasian /African American / Other _____

Date of Birth: _____/ _____ /_____ **Social Security #:** _____ - _____ - _____

Who may we thank for this referral? _____

Your Primary Care Physician: _____ **Phone** (_____)_____-_____

Please list Physicians (and their phone numbers) who have seen you for your DOL approved diagnosis:

_____**Phone:** (_____) _____ - _____

_____ **Phone:** (_____) _____ - _____

_____**Phone:** (_____) _____ - _____

_____ **Phone:** (_____) _____ - _____

Emergency Contact:

Name: _____ **Phone:** (_____) _____ - _____

Address: _____ **Cell Phone:** (_____) _____ - _____

Relationship to you: _____

CONSENT TO RELEASE INFORMATION

I,_____, give the Physician and office staff of Donald A. Lakatosh, M.D., p.a., my permission to discuss my health information (medical, financial, etc.) with the following people that I have listed below. This is an indefinite consent form which I may revoke this at anytime in writing. I also have been presented with a copy of Donald A. Lakatosh, M.D., p.a.'s, privacy policy.

PLEASE LIST FAMILY MEMBERS &/OR FRIENDS ONLY

WITH:_____WHO IS:_____AT PH#:_____
(RELATIONSHIP)

AND WITH:_____WHO IS:_____AT PH#:_____
(RELATIONSHIP)

_____ Date:_____
Signature of Client or Responsible Party

_____ Date:_____
Signature of Staff from Dr. Lakatosh's Office

HEALTH HISTORY

Your Full Name: _____ Age:_____ Gender: M / F Handedness: R / L

Today's Date:_____ Your Occupation: _____

Your Pharmacy: _____ Phone (____)_____-_____

Have you had a prior impairment rating for this condition? Yes or No

If yes, what was the percentage? _____

PAST MEDICAL HISTORY:

Have you had any of the following? (circle)

Cancer, radiation, chemotherapy	YES / NO	Blood clots	YES / NO
HIV/ Aids	YES / NO	Bleeding problems	YES / NO
Hepatitis	YES / NO	Hemophilia	YES / NO
Diabetes- insulin/ NO insulin	YES / NO	Sickle Cell Anemia	YES / NO
Asthma	YES / NO	Stomach Ulcers	YES / NO
Emphysema/ Bronchitis/ COPD	YES / NO	High Blood Pressure	YES / NO
Tuberculosis	YES / NO	Heart Disease	YES / NO
Thyroid problems	YES / NO	Other: _____	

FAMILY HISTORY: Do your immediate relatives have any of the following medical conditions?

	Age / Alive / Deceased	Conditions / Cause of Death If Deceased
Mother:		
Father:		
Brothers:		
Sisters:		

SURGICAL HISTORY: (What operations have you had and give dates please.)

_____

_____

_____

_____

_____

_____

_____

Client Name: _____ Date: _____

Review of Systems: (circle if positive)								
Constitutional:	Fever/Chills	Night sweats	Unexplained weight loss	Unexplained weight gain	Addt'l notes:			
Eyes:	Dry eyes	Irritation	Blury vision/Blindness	Addt'l notes:				
Ears:	Difficulty hearing	Ear pain	Addt'l notes:					
Nose:	Frequent nosebleeds	Nose/sinus problems	Addt'l notes:					
Mouth/Throat:	Sore Throat	Bleeding gums	Snoring	Dry mouth	Oral abnormality	Mouth Ulcer	Mouth breathing	Addt'l notes:
Cardiovascular:	Chest pain on exertion	Arm pain on exertion	Shortness of breath when walking	Shortness of breath when lying down	Palpitations	Known heart murmur	Light-headed on standing	Addt'l notes:
Respiratory:	Cough	Wheezing	Shortness of breath	Coughing up blood	Sleep apnea	Addt'l notes:		
Gastrointestinal:	Abdominal pain	Nausea/ vomiting/ constipation	Change in appetite	Black or tarry stools	Frequent diarrhea	Heartburn	Addt'l notes:	
Genitourinary:	Urinary loss of control	Difficulty urinating	Increased urinary frequency	Blood in urine	Incomplete emptying		Addt'l notes:	
Musculoskeletal:	Muscle aches	Muscle weakness	Joint pain/ stiffness	Back pain	Swelling in the extremities		Addt'l notes:	
Integumentary:	Abnormal	Jaundice	Rash	Itching	Dry skin	Growths/legions	Addt'l notes:	
Neurologic:	Dizziness	Migraines Frequent or severe headaches	Loss of consciousness	Weakness	Numbness	Seizures	Restless legs	Addt'l notes:
Psychiatric:	Alcohol abuse	Depression	Anxiety	Restless sleep	Feeling unsafe in relationship		Addt'l notes:	
Endocrine	Fatigue	Increased thirst	Hair loss	Increased hair growth	Cold intolerance		Addt'l notes:	
Hematologic/ Lymphatic:	Swollen glands	Easy bruising or bleeding	Lumps in neck, armpit or groin		Addt'l notes:			
Allergy/ Immunologic	Frequent colds or infections	Runny nose	Sinus pressure	Itching	Allergies or hives	Frequent sneezing	Addt'l notes	

Signature of Patient, Guardian, or Personal Representative: _____

Donald A. Lakatosh, M.D. Day Break, Adult Day Care Services 151 Linden Street, SW Aiken, SC 29801
Tel (865) 577-1914 Fax (865) 577-1714 email: physicalmedicine@dalakatosh.com or visit us at www.drlakatosh.com

Prescription Medication, Supplement And Over-the-Counter Medication Record

Patient Name: _____ **Date:** _____
Your Pharmacy: _____ **Phone:** (____)_____-_____

List all drug allergies and reaction _____

Prescription Medication Name:	Dose:	Frequency:	Prescribing Doctor:	Phone:

Over-the-Counter Medication Name:	Dose:	Frequency:	Taken For:

Supplement Name:	Dose:	Frequency:	Taken For:

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Donald A. Lakatosh, M.D.
407 North Forest Park Blvd.
Knoxville, TN 37919
(865) 577-1914 – telephone
(865) 577-1714 - facsimile

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates: _____
- Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION HAS NO EXPIRATION AFTER IT IS SIGNED.

Client Name: _____ Date: _____

IMPORTANT INFORMATION ABOUT YOUR IMPAIRMENT RATING

1. Please bring a picture ID along with your DOL/EEOIC claim card as these are necessary to complete your examination in a timely fashion.

2. If you are unable to keep the date and time of this scheduled examination that has been assigned to you, please call to make other arrangements.

3. Please be prompt. Please plan to arrive on time to prevent any delays in your evaluation. We reserve the right to reschedule you if you are late. Please plan on being here for at least 1-2 hours.

4. Dr. Lakatosh will be seeing you an impairment rating. Although he may make recommendations, **he is not your treating physician.** He does not make the final decision regarding your claim and he does not make treatment decisions or implement your treatment.

5. The report of your Impairment Rating will be sent directly to whoever referred you to us and you should contact them to get a copy of this report. **Please do not call our office for information about your report.**

6. Do not ask the doctor for any medical advice, to write any prescriptions, or to complete medical report forms, disability report forms, or other insurance company forms for other agencies.

7. If you wear glasses, use any type of medical devices, use hearing aids or other assistive devices, such as canes, crutches, walkers, and/or braces, be sure to bring those with you to your examination.

8. Continue to use all prescribed medication, as prescribed by your treating physician, and bring all of your medications with you in the containers in which they were dispensed by the pharmacy to the examination. Bring only medication that you are currently using.

9. If you have a disability or are unable to read, please bring a person with you to help you fill out any paperwork that you have to complete at the time of the examination.

10. You should not receive a bill for this Impairment Rating. However, if by mistake you are billed, please notify this office immediately and do not submit it to your insurance carrier for payment.

_____ Date:_____

Signature of Client

_____ Date:_____

Signature of Staff from Dr. Lakatosh's Office

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