☐ New Patient ☐ Updated Information

Patient Demographics

Patient Name: _____ Birth Date: _____/_____/_____
LAST FIRST MI

Social Security No: _____-_____-_____ Gender: ☐ Male ☐ Female

Address: _____
STREET ADDRESS CITY STATE ZIP

Home #: ____-_____-_____ Cell #: _____-_____-_____ Work #:_____-_____-_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Preferred Language:_____

Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic
☐ Native Hawaiian / Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic or Latin Decent ☐ Not Hispanic or Latin Decent ☐ Do Not Wish to Report

Emergency Contact Information

Name: _____ Phone: _____-_____-_____

Release of Medical Information

(Medical Information may be released to the following individuals)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Payment Information

Form of Payment: ☐ Health Insurance ☐ Auto Insurance ☐ Workers Comp ☐ Self Pay ☐ Other

Primary Insurance:

Primary Company:_____ Insured's Name:_____

Policy #:_____ Group #:_____ Insured's Date of Birth :_____

Secondary Insurance

Secondary Company:_____ Insured's Name:_____

Policy #:_____Group #:_____ Insured's Date of Birth :_____

Self Pay Agreement

I agree to pay for medical services rendered from South Texas Bone & Joint Institute, PLLC. I understand that payment arrangements must be made prior to establishing as a new patient.

Patient Signature: _____ Date: _____

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION:

I authorize South Texas Bone & Joint Institute PLLC to release any medical information requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my medical care.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:

I authorize the release of any medical information necessary to process any claim associated with South Texas Bone & Joint Institute PLLC with respect to my medical care. I permit a copy of this authorization to be used in the place of the original.

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of benefits to be paid directly to South Texas Bone & Joint Institute PLLC. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney fees.

CONSENT FOR TREATMENT:

I hereby authorize the health care providers at South Texas Bone & Joint Institute PLLC to perform a physical examination and to provide any medical treatment deemed necessary. This includes but not limited to all required medical examinations, x-rays, and/or medical/ surgical procedures.

NOTICE OF PRIVACY PRACTICES:

South Texas Bone & Joint Institute PLLC is required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing below indicated acknowledgement of receipt of our office's Notice of Privacy Practices.

AUTHORIZED SIGNATURE:

I authorize that I have read this document and completed the requested information to the best of my ability.

_____ _____ _____

Patient Name (Please Print) Date Patient Signature

Sign and date below for a patient that is a minor:

_____ _____ _____

Parent / Guardian Name Date Signature of Parent or Legal Guardian

Guardian Information: (If Patient is a Minor)

Name: _____ Relationship to Patient: _____

SS#: _____-_____-_____ Birth date: _____/_____/_____ Gender:☐Male ☐Female

Address: _____

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

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of South Texas Bone & Joint Institute, PLLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of South Texas Bone & Joint Institute, PLLC reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of South Texas Bone & Joint Institute, PLLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of South Texas Bone & Joint Institute, PLLC may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the office of South Texas Bone & Joint Institute, PLLC may e-mail to my home or other alternative location any times that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of South Texas Bone & Joint Institute, PLLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting that the office of South Texas Bone & Joint Institute, PLLC may use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the office of South Texas Bone & Joint Institute, PLLC may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____

Print Patient's Name

_____

Print Name Legal Guardian

_____

Date

Medical Questionnaire

Patient Name (Please Print): _____ Date: _____/_____/_____

DOB: _____/_____/_____ Gender: ☐ Female ☐ Male Height: _____/_____ Weight: _____

Did you bring X-Ray? ☐ Yes ☐ No Labs? ☐ Yes ☐ No

Who requested that you visit our office: ☐ Doctor (Name) _____ ☐ Self-Referral ☐ Attorney

What is the main Reason for this visit? (Chief Complaint) _____

_____.

What Body Part is Involved?													
Neck	☐	Shoulder	☐ R ☐ L	Elbow	☐ R ☐ L	Hand	☐ R ☐ L	Pelvis	☐ ☐	Knee	☐ R ☐ L	Foot	☐ R ☐ L
Back	☐ Mid ☐ Lower	Arm	☐ R ☐ L	Wrist	☐ R ☐ L	Finger	☐ R ☐ L	Hip	☐ ☐	Ankle	☐ R ☐ L	Toe	☐ R ☐ L

How long has this Problem been present? _____ ☐ Days ☐ Weeks ☐ Months ☐ Years

Are you right handed or left handed? ☐ Right ☐ Left

Can you walk? ☐ Yes ☐ No If so, how far? _____

In a motor or vehicle accident? ☐ Yes ☐ No Can you go up and down stairs? ☐ Yes ☐ No

Did you have a work injury? ☐ Yes ☐ No If so was it… _____

What activities would you like to do that you cannot currently do? _____

Other type of injury? _____

Date of Injury? _____

Litigation Pending? ☐ Yes ☐ No

Was Onset: ☐ Gradual or ☐ Sudden Answer:

Please check the box below which best describes your problem:

The pain is: ☐ Constant ☐ Comes and goes (Intermittent)

Severity of Pain ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely Severe

What is the Quality of pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

☐ Other: _____

Are there associated symptoms? ☐ Swelling ☐ Numbness ☐ Weakness

Since my problem started it is: ☐ Getting better ☐ Getting Worse ☐ Unchanged

Does your pain wake you from your sleep? ☐ Yes ☐ No

What makes your symptoms worse? ☐ Activity ☐ Exercise ☐ Work

☐ Other: _____

Which makes you feel better? ☐ Rest ☐ Heat ☐ Ice ☐ Elevation

Do you have any of the following? ☐ Fever ☐ Chills ☐ Sweats

Do you have difficulty in controlling your own bowels or bladder? ☐ Yes ☐ No

Check which treatments you have had for today's problem:

☐ Injection ☐ Brace ☐ Therapy ☐ Cane/Crutch ☐ Chiropractor ☐ Orthotics ☐ Other

PREVIOUS INJURIES

Have you had any prior problem with this same orthopedic condition in the past? ☐ Yes ☐ No (Explain Below)

If yes, When? _____

What Diagnostic tests have you had for this problem?

☐ X-Rays ☐ Bone Scan ☐ Myelogram ☐ MRI

☐ EMG / NCS ☐ Dexa Scan ☐ CT Scan ☐ Other: _____

PAST MEDICAL HISTORY ☐ None

Do you have any of the following medical problems? Please check the ones that apply

☐ AIDS / HIV	☐ Bleeding Problems	☐ COPD	☐ Stroke
☐ Migraines	☐ Emphysema / Asthma	☐ Hepatitis A,B,C	☐ Polio
☐ Anemia	☐ Fibromyalgia	☐ Osteoporosis	☐ Stomach Problems (Ulcers, Reflux)
☐ Arthritis	☐ Heart Problems	☐ Nerve Problems	☐ Thyroid Problems
☐ Diabetes	☐ Kidney Problems	☐ Pneumonia	☐ Blood Clots (DVT, PE)
☐ Epilepsy	☐ High Blood Pressure	☐ Psychiatric Disorders	☐ Rheumatoid Arthritis
☐ Gout	☐ Muscle Diseases	☐ Depression / Anxiety	☐ Other / None

☐ Cancer TYPE: ☐ Breasts ☐ Prostate ☐ Lung ☐ Thyroid ☐ Myeloma ☐ _____

Patient Name (Please Print): _____ DOB: _____/_____/_____

PAST SURGICAL HISTORY ☐ None

Have you had any of the following surgeries? Please check the ones that apply and give the date

Arthroscopy	☐ Left	☐ Right	☐ Ankle	☐ Knee	☐ Shoulder	☐ Wrist				☐	____/____
Replacement	☐ Left	☐ Right	☐ Ankle	☐ Knee	☐ Shoulder	☐ Hip	☐ Elbow			☐	____/____
Fracture Fixation	☐ Left	☐ Right	☐ Ankle	☐ Calcaneus	☐ Elbow	☐ Femur	☐ Foot			☐	____/____
			☐ Forearm	☐ Shoulder	☐ Hip	☐ Tibia	☐ Wrist				

ACL Reconstruction	☐ ____/____	Cervical Fusion	☐ ____/____	Lumbar Fusion	☐ ____/____		
Brain Surgery	☐ ____/____	Hand Surgery	☐ ____/____	Pacemaker	☐ ____/____		
Breast Surgery	☐ ____/____	Intramedullary Nail Femur	☐ ____/____	Splenectomy	☐ ____/____		
Cardiac Stent	☐ ____/____	Intramedullary Nail Tibia	☐ ____/____	Thoracic Fusion	☐ ____/____		
Cardiac Surgery	☐ ____/____	Thoracic Discectomy	☐ ____/____		☐ ____/____		
Carpel Tunnel	☐ ____/____	Lumbar Discectomy	☐ ____/____		☐ ____/____		

FAMILY HISTORY:

DESCRIPTION OF ILLNESS	MOTHER	FATHER	BROTHER	SISTER
Heart Disease / CAD				
High Blood Pressure				
Sudden Death				

SOCIAL HISTORY:

Marital Status**:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced Occupation:

DESCRIPTION	USE	TYPE	FREQUENCY	AMOUNT	YEARS
Alcohol	Y / N				
Recreational Drugs	Y / N				
Smoking	Y / N				
Vioxx / Diet Pills	Y / N				
Vitamins / Herbal Supp.	Y / N				

REVIEW OF SYMPTOMS: Do you <u>currently</u> have any of the following medical symptoms? Please check those that apply.

CONSTITUTIONAL
- ☐ Blood Pressure
- ☐ Respiration
- ☐ Fever / Sweats
- ☐ Fatigue
- ☐ Loss of Appetite / Weight Change

EYES
- ☐ Eye disease of Injury
- ☐ Eye glasses / Contact Lenses
- ☐ Blurred / Double Vision
- ☐ Glaucoma

EARS / NOSE / MOUTH / THROAT
- ☐ Hearing Loss
- ☐ Hearing Noises in your Ear
- ☐ Earaches and drainage
- ☐ Nosebleeds
- ☐ Trouble swallowing
- ☐ Bleeding gums
- ☐ Sore throat
- ☐ Snoring
- ☐ Voice Changes
- ☐ Problems with Thyroid

MUSCULOSKELETAL
- ☐ Joint pain / Stiffness
- ☐ Muscle pain / Cramps / Weakness
- ☐ Back pain

SKIN
- ☐ Rashes
- ☐ Lesions
- ☐ Ulcers

CARDIOVASCULAR
- ☐ Chest Pain / Angina
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of feet, ankles, or hands
- ☐ Murmur

RESPIRATORY
- ☐ Cough
- ☐ Spitting up Blood
- ☐ Shortness of breath
- ☐ Wheezing

OTHER
- ☐ Memory loss / Confusion
- ☐ Nervousness / Anxiety

GASTROINTESTINAL
- ☐ Problems with bowel movements
- ☐ Nausea / Vomiting
- ☐ Rectal Bleeding / Blood in stool
- ☐ Abdominal pain / Heartburn

GENITOURINARY
- ☐ Flank Pain
- ☐ Problems with Urination
- ☐ Blood in Urine
- ☐ Kidney Stone

NEUROLOGICAL
- ☐ Headaches
- ☐ Numbness / Tingling Sensation
- ☐ Tremors
- ☐ Head Injury

HEMATOLOGIC / LYMPHATIC
- ☐ Slow to heal after cuts
- ☐ Tendency to bleed / Bruise
- ☐ Blood clots
- ☐ Past blood transfusion

- ☐ Depression
- ☐ Insomnia

Are you independent in normal daily activities? ☐ Yes ☐ No Has this changed recently? ☐ Yes ☐ No

Patient Name (Please Print): _____ DOB: _____/_____/_____

CURRENT MEDICATIONS:	DOSAGE	CURRENT MEDICATIONS:	DOSAGE

Preferred Pharmacy Name:
Preferred Pharmacy Phone Number: ( ) -
Medication Allergies: ☐ Yes ☐ No If yes, Please List:
Have you ever had a reaction to anesthesia? ☐ Yes ☐ No
Patient Signature: **Date:** / /