PLEASE PRINT

PATIENT REGISTRATION

Acct #_____

PATIENT LAST NAME | FIRST NAME | MIDDLE | SUFFIX

SOCIAL SECURITY NUMBER | **EMAIL** | DRIVER'S LICENSE NUMBER & STATE

DATE OF BIRTH | AGE | SEX | RACE | ETHNICITY

ADDRESS (PERMANENT) | STREET | APT# | CITY | STATE | ZIP

HOME PHONE | CELL PHONE | MARITAL STATUS | NUMBER OF DEPENDENTS

EMPLOYED BY | EMPLOYER'S ADDRESS | OCCUPATION | BUS PHONE

SPOUSE'S NAME | EMPLOYED BY | EMPLOYER'S ADDRESS | BUS PHONE | DATE OF BIRTH

PATIENT'S (TEMPORARY ADDRESS) | SPOUSE'S OCCUPATION

NEAREST FRIEND OR RELATIVE FOR EMERGENCIES | RELATIONSHIP TO PATIENT | PHONE

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

RESPONSIBLE/INSURED PARTY
IF PATIENT NOT RESPONSIBLE FOR THE BILL, PLEASE INDICATE WHO IS RESPONSIBLE FOR THE BILL

NAME | ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | RELATIONSHIP TO PATIENT | INSURED PARTY DATE OF BIRTH

EMPLOYER | EMPLOYER'S ADDRESS | CITY | STATE | ZIP CODE | BUS PHONE

Insurance Name: _____

Insurance Claims Mailing Address: _____

INSURED PARTY'S SOCIAL SECURITY NUMBER | INSURED PARTY'S DRIVER'S LICENSE NUMBER

PLEASE INDICATE METHOD OF PAYMENT FOR TODAY'S VISIT ____ CHECK ____ CASH OTHER_____

REQUEST FOR PAYMENT OF, MEDICAL SERVICES AND LABORATORY TESTS AT OUR OFFICE WILL BE MADE AT THE TIME OF YOUR VISIT. BY ASKING YOU TO DO THIS WE CAN DOWN THE COST OF BILLING, BOOKKEEPING:
AND HOPEFULLY, KEEP YOUR MEDICAL FEES DOWN.

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ALL CHARGES INCURRED ON BEHALF OF MYSELF AND MY FAMILY REGARDLESS OF INSURANCE BENEFITS.

_____ _____ DATE

RESPONSIBLE PARTY SIGNATURE

Texas Orthopaedic Surgical Associates

Patient Name: _____Date:_____ Acct#_____
Height: _____Weight: _____ Age: _____
Primary Care Doctor or Clinic: _____
Were you referred to this office? □ Yes □ No **By whom? _____**
If no referral, how did you hear about us? _____
Estimated Date of Injury: _____ is **this work related?** □ Yes □ No
Name/Location Pharmacy: _____
Name Street Address City Telephone

Medical History
Are you allergic to any medications? □ Yes □ No **Are you allergic to iodine?** □ Yes □ No
Please list medication **AND reaction: _____**
Do you have any food allergies? □ Yes □ No **Do you have any allergies to shellfish?** □ Yes □ No
Please list food with reaction: _____
Are you allergic to any metals? □ Yes □ No
Please list metal with reaction: _____
Are you allergic/sensitive to latex? □ Yes □ No **Are you allergic/sensitive to adhesive?** □ Yes □ No
Please list reaction: _____
Any other allergies? □ Yes □ No
Please list with **reaction**: _____
Current Medications include MG and Dosages: _____
_____
_____
_____

Social History
Do you smoke or have you ever smoked? Do you use any tobacco products? □ Yes □ No
When did you quit? _____Total years smoking? _____
How much do you smoke; number of packs per day? _____
Do you drink alcohol? □ Yes □ No□ **Less than 1 drink/day** □ **1-2 drinks/day** □**3 or more drinks/day**
Have you ever been treated for alcoholism, drug or substance abuse? □ Yes □ No
What is your caffeine use? □ **Coffee** □ **Tea**□ **Chocolate**□ **1 daily** □ **Several times a day** □ **A few times a week** □**A few times a month**
Do you work? □ Yes □ No **What type of work do you do?**

Do you live alone? □ Yes □ No **Do you feel safe at home?** □ Yes □ No _____
Driving Status: □ **Drives in the Daytime** □ **Drives at Night**
Do you exercise? □ Yes □ No□ **Several times/day** □**Once a day** □ **A few times/week**□ **A few times a month**
Women: Is there any chance you might be pregnant? □ Yes □ No **Planning pregnancy** □ Yes □ No

Family History
Please select the family member with the following conditions.
Arthritis □ None □ Mother □ Father □ Son □ Daughter □ Brother □ Sister □ Grandmother □ Grandfather
Hypertension □ None □ Mother □ Father □ Son □ Daughter □ Brother □ Sister □ Grandmother □ Grandfather
Cancer □ None□ Mother □ Father □ Son □ Daughter □ Brother □ Sister □ Grandmother □ Grandfather
Diabetes □ None□ Mother □ Father □ Son □ Daughter □ Brother □ Sister □ Grandmother □ Grandfather
Blood Clots/Bleeding □ None□ Mother □ Father □ Son □ Daughter □ Brother □ Sister □ Grandmother □ Grandfather
Cardiac Disorders □ None □ Mother □ Father □ Son □ Daughter□ Brother □ Sister □ Grandmother □ Grandfather
Mental Health Disorders □ None □ Mother □ Father □ Son □ Daughter □ Brother □ Sister □ Grandmother □ Grandfather
Reactions to Anesthesia □ None □ Mother □ Father □ Son □ Daughter □ Brother □ Sister □ Grandmother □ Grandfather

Patient Name: _____**Date:**_____**Acct#**_____

Past History: Have you had in the past?

Please check all that apply)

☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial fibrillation
☐ Bone Marrow Transplantation
☐ Breast Cancer
☐ Colon Cancer
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ End Stage Renal Disease
☐ GERD
☐ Hearing Loss
☐ Hepatitis
☐ High Blood pressure
☐ HIV/AIDS
☐ High Cholesterol
☐ Thyroid Problems
☐ Leukemia
☐ Lung Cancer
☐ Lymphoma
☐ Prostate Cancer
☐ Radiation Treatment
☐ Seizures
☐ Stroke
☐ None

Other
_____
_____

Review of Systems: Do you currently have any of the following?

Constitutional: □ None of below listed symptoms
□ Cancer, where/type _____ □ Infection □ Fever □ Chills □ Warmth □ Fatigue □ Insomnia
□ Weight loss □ Weight gain □ Premedication prior to procedures □ Under Pain Management
□ Other _____

Musculoskeletal: □ None of below listed symptoms
□ Osteoarthritis □ Neck Pain □ Back Pain □ Joint swelling □ Joint stiffness □ Arthritis
□ Limping □ Loss of Motion □ Unsteady Gait □ Locking □ Gout □ Rheumatoid Arthritis
□ Other_____

Cardiovascular: □ None of below listed symptoms
□ Chest Pain □ Palpitations □ High Blood Pressure □ Leg cramps □ Pacemaker □ Defibrillator
□ Blood thinners □Other_____

Respiratory: □ None of below listed symptoms
□ Cough □ Asthma □ COPD □ Emphysema □ Pneumonia □ Tuberculosis □ Other_____

Gastrointestinal: □ None of below listed symptoms
□ Reflux/GERD □ Ulcer □ Polyps □ Ulcerative Colitis □ Nausea/Vomiting □ Constipation
□ Diarrhea □ Jaundice □ Hepatitis____ □ Cirrhosis □ Choleycystitis/Gall Stones
□ Other _____

Neurological: □ None of below listed symptoms
□ Numbness □ Tingling □ Dizziness □ Headaches □ RSD □ Other _____

Genitourinary/Nephrology: □ None of below listed symptoms
□ Frequent Urination □ Difficult/Painful Urination □ Incontinence □ Blood in Urine □ Stones
□ Dialysis □ Renal Disease □ Other_____

Integumentary/Dermatologic: □ None of below listed symptoms
□ Poor healing wounds □ Itching □ Eczema □ Rash □ Impetigo □ Psoriasis □ Skin Cancer
□ Scarring/Keloids □ Redness □ Other _____

Psychiatric: □ None of below listed symptoms
□ Bipolar □ Depression □ Schizophrenia □ Other _____

Hematologic: □ None of below listed symptoms□ HIV+ □ Easy Bleeding □ Anemia □ Easy Bruising
□ Blood thinners □ Other_____

Endocrine: □ None of below listed symptoms □ Insulin dependent □ Non-insulin dependent □ Hypothyroid
□ Hyperthyroid □ Other_____

Patient Name: _____Date:_____Acct#_____

Past Surgical History: (please check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy:
  - ☐ Right ☐ Left ☐ Both
- ☐ Lumpectomy:
  - ☐ Right ☐ Left ☐ Both
- ☐ Breast Biopsy:
  - ☐ Right ☐ Left ☐ Both
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement within last 2 yrs
- ☐ Kidney Biopsy
- ☐ Kidney Removed:
  - ☐ Right ☐ Left
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed
  - ☐ Right ☐ Left ☐ Both
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ None

Other _____

Orthopedic History: (please check all that apply)

- ☐ Ankylosing Spondylitis
- ☐ Bursitis
- ☐ DISH
- ☐ Distal Radius Fracture
- ☐ Epidural Injections, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatic
- ☐ Scoliosis
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ **None**

Other_____

Orthopedic Surgery: (please check all that apply)

- ☐ Ankle Fracture:
  - ☐ Right ☐ Left ☐ Both
- ☐ Carpal Tunnel Decompression:
  - ☐ Right ☐ Left ☐ Both
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ Distal Radius ORIF:
  - ☐ Right ☐ Left ☐ Both
- ☐ Intermedullary Nailing Femur
  - ☐ Right ☐ Left ☐ Both
- ☐ Intermedullary Nailing Tibia:
  - ☐ Right ☐ Left ☐ Both
- ☐ Rotator Cuff Repair:
  - ☐ Right ☐ Left ☐ Both
- ☐ Joint Replacement: Hip
  - ☐ Right ☐ Left ☐ Both
- ☐ Joint Replacement: Knee
  - ☐ Right ☐ Left ☐ Both
- ☐ Joint Replacement: Shoulder
  - ☐ Right ☐ Left ☐ Both
- ☐ Knee Arthroscopy:
  - ☐ Right ☐ Left ☐ Both
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Lumbar Spine Surgery: Decompression
- ☐ Lumbar Spine Surgery: Decompression and Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement

Other_____

☐ **None**

Patient Name: _____**Date:**_____**Acct#**_____

History of Present Illness

Please mark the reason for your visit today.

□ Neck □ Arm □ Shoulder □ Elbow □ Forearm □ Wrist □ Hand
□ Finger □ Back □ Hip □ Knee □ Leg □ Ankle □ Foot

Which side? □ Right □ Left □ Both

How would you describe your pain?

□ Aching □ Dull □ Sharp □ Throbbing □ Worsening □ Improving □ Constant
□ Intermittent □ Locking □ Other_____

When did your pain start?

□ ___hrs ago □ ___days ago □ ___weeks ago □ ___months ago □ ___years ago
□ Other _____

When does your pain occur?

□ In the morning □ At night □ Awakening from sleep □ With weight bearing activity
□ Other _____

How severe is your pain? □ Mild □ Moderate □ Severe

How does this limit daily activities?

□ Does not limit activities □ Moderately limit activities □ Severely limits activities
□ Other_____

What do you think caused your current problem?

□ Trauma □ Work Related □ Repetitive Movements □ Other _____

What makes it better?

□ Rest □ Ice □ Immobilization □ Heat □ Medications □ Physical Therapy
□ Other_____

What makes it worse?

□ Movement □ Rest □ Pushing/Pulling □ Lying down □ Standing □ Lifting □
Other_____

Have you been treated for this problem before? □ Yes □ No
Please list Doctor or Care Giver's that you have previously seen for this problem:

_____

Have you had tests for this problem? □ Yes □ NO

□ X-Ray □ MRI □ CT □ EMG □ CT / Myelogram □ Bone Scan □ Discography
□ Other _____

Have you had treatments for this problem? □ Yes □ No

□ Physical Therapy/Occupational Therapy □ Injections □ Acupuncture □ Chiropractic Care
□ Other_____

Medications:

□ Muscle Relaxants □ Pain Medications □ Anti-inflammatory □ Over the counter Medications
(Aspirin, Tylenol, Advil, Aleve, etc)

Patient's Full Name: _____

Account #_____

AUTHORIZATION TO RELEASE INFORMATION

I authorize *Oak Cliff Orthopaedic* Associates DBA Texas Orthopaedic Surgical Associates to furnish requested information from the patient's medical and other records to 1) any insurance company or third party payer for the purpose of obtaining payment on the account of *Oak Cliff Orthopaedic Associates DBA Texas Orthopaedic Surgical Associates*, 2) any other person(s) or entities financially responsible for the patient's care or treatment, and 3) representatives of local, state, or federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable diseases such as Acquired Immune Deficiency Syndrome (AIDS). I authorize the release of information from or the review of the patient's records for the purpose of conducting any medical audit, utilization reviews, or quality assurance reviews. I authorize *Oak Cliff Orthopaedic Associates DBA Texas Orthopaedic Surgical Associates* to release information from or copies of the patient's medical record to any referring physician or to any skilled nursing facility or other health care facility to which patient may be transferred.

Patient's Signature _____

Spouse/Guardian's Signature _____

Witness's Signature _____ Date _____

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of services rendered, I hereby transfer and assign *Oak Cliff Orthopaedic Associates DBA Texas Orthopaedic Surgical Associates* all right, title, and interest in any payment due me for services described herein as provided in any policy or policies of insurance. I understand that I am responsible for providing to *Oak Cliff Orthopaedic Associates DBA Texas Orthopaedic Surgical Associates* all insurance information at the time of my admission or during my hospital stay to allow for verification prior to my discharge, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

Patient's Signature _____

Spouse/Guardian's Signature _____

Witness's Signature _____Date _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

Please PRINT Patient Name:_____ Acct#_____

I consent to the use or disclosure of my protected health information by Texas Orthopaedic Surgical Associates for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Texas Orthopaedic Surgical Associates. I understand that diagnosis or treatment of me by Dr. Berry, Dr. Kelley, Dr. Cho, Dr. Hernandez, Dr. Aronowitz, Dr. Heck, Dr. Lowry or Dr. Nathanson may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Texas Orthopaedic Surgical Associates is not required to agree to the restrictions that I may request. However, if Texas Orthopaedic Surgical Associates agrees to a restriction that I request, the restriction is binding on Texas Orthopaedic Surgical Associates and Dr. Berry, Dr. Kelley, Dr. Cho, Dr. Hernandez, Dr. Aronowitz, Dr. Heck, Dr. Lowry or Dr. Nathanson. I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Berry, Dr. Kelley, Dr. Cho, Dr. Hernandez, Dr. Aronowitz, Dr. Heck, Dr. Lowry or Dr. Nathanson or Texas Orthopaedic Surgical Associates has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Texas Orthopaedic Surgical Associates' Notice of Privacy Practices prior to signing this document. The Texas Orthopaedic Surgical Associates ' Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Texas Orthopaedic Surgical Associates. The Notice of Privacy Practices for Texas Orthopaedic Surgical Associates is also provided at 810 N. Zang Blvd., Dallas, TX 75208 and on Texas Orthopaedic Surgical Associates website at thebonedocs.com. This Notice of Privacy Practices also describes my rights and the Texas Orthopaedic Surgical Associates' duties with respect to my protected health information.

Texas Orthopaedic Surgical Associates reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Texas Orthopaedic Surgical Associates ' website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority