PLEASE PRINT

# PATIENT REGISTRATION

Acct #_____

PATIENT LAST NAME | FIRST NAME | MIDDLE | SUFFIX

SOCIAL SECURITY NUMBER | 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**

**NO PATIENT CAN BE SEEN UNTIL THIS FORM IS COMPLETED IN ITS ENTIRETY**

# Texas Orthopaedic Surgical Associates

**Acct#_____**

**Patient Name: _____Date:_____**
**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
Please list medication **AND reaction: _____**
**Do you have any food allergies?** □Yes □No
Please list food with reaction: _____
**Are allergic to any metals?** □Yes □No
Please list metal with reaction: _____
**Are you allergic/sensitive to latex?** □Yes □No
Please list latex with reaction: _____
**Any other allergies?**
Please list with **reaction**: _____

**Current Medications include MG and Dosages: _____**
_____

**Surgical History**
**Have you ever had surgery?** □Yes □ No
Please list with date: _____

**Social History**
**Do you smoke or have you ever smoked? Do you use any tobacco products?** □ Yes □No
**When did you quit? _____**
**How much do you smoke? _____**
**Do you drink alcohol?** □ Yes □ No
**Have you ever been treated for alcoholism, drug or substance abuse?** □ Yes □ No
**Do you work?** □ Yes □ No
**What type of work do you do?**
**Are you** □ Married □ Single □ Divorced □ Widowed?
**Do you have children?** □Yes □ No **How many? _____**
**Do you live alone? _____**
**Do you exercise?** □Yes □ No **How often? _____**
**Women: Is there any chance you might be pregnant?** □ 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?

| | | | |
|---|---|---|---|
| Diabetes | □ Yes □ No | Jaundice, Liver trouble | □ Yes □ No |
| Arthritis | □ Yes □ No | Hepatitis_____ | □ Yes □ No |
| Back Pain or Injury | □ Yes □ No | Cirrhosis | □ Yes □ No |
| Depression | □ Yes □ No | Hypothyroid | □ Yes □ No |
| Asthma | □ Yes □ No | Hyperthyroid | □ Yes □ No |
| Bronchitis / Chronic Cough | □ Yes □ No | Seizures | □ Yes □ No |
| Tuberculosis | □ Yes □ No | Epilepsy | □ Yes □ No |
| Hypertension/ High Blood pressure | □ Yes □ No | Cancer | □ Yes □ No |
| Palpitations / Irregular heartbeat | □ Yes □ No | HIV | □ Yes □ No |
| Anemia | □ Yes □ No | Syphilis | □ Yes □ No |
| Bleeding Disorders | □ Yes □ No | Sickle Cell Disorder | □ Yes □ No |
| Gastrointestinal Reflux Disease | □ Yes □ No | Hemophilia | □ Yes □ No |
| Ulcerative Colitis | □ Yes □ No | | |
| Ulcers | □ Yes □ No | Any other medical problems not listed: | |
| Gastritis | □ Yes □ No | _____ | |
| Hemorrhoids | □ Yes □ No | _____ | |

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

**General:** □ None of below listed symptoms
□ Cancer, where _____ □ Infection □ Fever □ Tingling □ Warmth □ Swelling □ Redness
□ Numbness □ Easy Bruising □ Loss of Motion □ Instability □ Limping □ Locking □ Fatigue
□ Weight loss □ Insomnia □ Other _____

**Cardiovascular:** □ None of below listed symptoms
□ Heart Attack □ Chest Pain □ Palpitations □ High Blood Pressure □ Other_____

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

**Gastrointestinal**: □ None of below listed symptoms
□ Reflux/GERD □ Ulcer □ Polyps □ Ulcerative Colitis □ Other_____

**Liver:** □ None of below listed symptoms
□ Jaundice □ Hepatitis____ □ Cirrhosis □ Choleycystitis/Gall Stones □ Other _____

**Nephrology**: □ None of below listed symptoms
□ Incontinence □ Stones □ Dialysis □ Renal Disease □
Other_____

**Reproductive/Sexual**: □ None of below listed symptoms
□ Pregnancy □ HIV □ Syphilis □ Other _____

**Musculoskeletal**: □ None of below listed symptoms
□ Osteoarthritis □ Neck Pain □ Back Pain □ Arthritis □ Gout □ Other_____

**Dermatologic:** □ None of below listed symptoms
□ Eczema □ Rash □ Impetigo □ Psoriasis □ Skin Cancer □ Other _____

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

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

**Hematologic**: □ None of below listed symptoms
□ Abnormal Bleeding □ Anemia □ Other_____

**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*, 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