TEXAS ORTHOPEDICS, SPORTS AND REHABILITATION ASSOCIATES

Name: ____________________ **Appt Date:** __________ **With Doctor:** __________

Age: ______ **Sex:** ☐ Male ☐ Female **Dominant Hand:** ☐ Right ☐ Left **Height:** __________

Who is your primary physician? ____________________; **Clinic Name:** ____________________

Staff Use Only
Wt

WHO REFERRED YOU TO OUR OFFICE?

☐ Doctor ____________________ ☐ Friend ____________________

☐ Coach/Trainer ____________________ ☐ Hospital/ER ____________________

☐ Phone Book ☐ Website ☐ Insurance Plan ☐ Other ____________________

CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS

What is your chief complaint and location of pain? ____________________ ☐ Right ☐ Left

How long have you had this problem? ______ days ______week(s) ______month(s) ______years(s)

How did the injury occur (if applicable): ____________________ ***(please complete full details on Accident/Injury page)***

On a scale of 0-10 how severe is your pain? None - 0 1 2 3 4 5 6 7 8 9 10 – Severe

Quality of Pain: ☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing ☐ Burning ☐ Knots ☐ Electric Shocks ☐ Numbness ☐ Tingling

The Pain is: ☐ Constant ☐ Intermittent (off and on) ☐ Wakes me at night

Do you have any of the following associated symptoms: ☐ Swelling ☐ Popping (audible/feel) ☐ Catching ☐ Locking ☐ Giving Way ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of bowel or bladder control

What makes your symptoms worse? ☐ Standing ☐ Walking ☐ Running ☐ Exercise ☐ Sitting ☐ Lifting ☐ Twisting ☐ Stairs ☐ Lying in bed ☐ Bending ☐ Squatting ☐ Kneeling ☐ Coughing ☐ Sneezing ☐Rising from a chair

What treatments and/or surgery have you had for this problem?

☐ Rest	___Helpful	___Not Helpful	☐ Therapy	___Helpful	___Not Helpful
☐ Elevation	___Helpful	___Not Helpful	☐ Medication	___Helpful	___Not Helpful
☐ Heat	___Helpful	___Not Helpful	☐ Injection	___Helpful	___Not Helpful
☐ Cold	___Helpful	___Not Helpful	☐ Cane	___Helpful	___Not Helpful
☐ Brace/Bandage	___Helpful	___Not Helpful	☐ Crutch	___Helpful	___Not Helpful

What tests have you had for this problem? ☐ Xrays ☐MRI ☐CT Scan ☐ Bone Scan ☐ EMG/NCV ☐ Where?________

REVIEW OF SYSTEMS (Please only check **CURRENT** problems)

Constitutional	☐None	☐ Weight Loss	☐ Loss of appetite			
Eyes	☐None	☐ Blurred Vision	☐ Double Vision	☐ Vision loss	☐ Eye discomfort	☐ Dryness
Ears-Nose-Throat	☐None	☐ Trouble swallowing	☐ Hoarseness	☐ Hearing loss	☐ Nosebleeds	
Cardiovascular	☐None	☐ Chest pain	☐ Irregular heartbeat	☐ Palpitations	☐ Calf Pain	
Respiratory	☐None	☐ Shortness of Breath	☐ Chronic cough	☐ Wheezing		
Gastrointestinal	☐None	☐ Heartburn	☐ Ulcers	☐ Nausea, Vomiting	☐ Blood in stool	☐ Diarrhea
Genitourinary	☐None	☐ Painful urination	☐ Blood in urine	☐ Difficult urination	☐ Frequent at night	☐ Possible pregnancy
Skin	☐None	☐ Frequent rashes	☐ Skin ulcers	☐ Psoriasis	☐ Lumps	
Neurological	☐None	☐ Headaches	☐ Dizziness	☐ Seizures	☐ Memory difficulties	☐ Numbness
Musculoskeletal	Do your other joints have: ☐ Morning stiffness lasting over 30 minutes? ☐ Joint pain or swelling? ☐ Back/neck pain ☐ Gout					
Endocrine	☐None	☐ Heat or Cold intolerance	☐ Excessive thirst			
Psychological	☐None	☐ Depression	☐ Anxiety	☐ Difficulty sleeping	☐ Other psychiatric disorder	
Hematologic	☐None	☐ Easy bleeding	☐ Easy Bruising	☐ Swollen glands		

PLEASE SIGN: The information on this form in its entirety is accurate to the best of my knowledge.

Signature ______________________________ **Date** ____________

If other than patient, relationship to patient ____________________

Name: ______________________ **(please print)** **Acct #:** ____________ **Dr:** __________

PAST MEDICAL HISTORY

Do you now or have you ever had any of the following:

- ❑ Addiction
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anxiety disorder
- ❑ Asthma
- ❑ Bleeding problems
- ❑ Cancer (Specify): ______________________
- ❑ CVA (Stroke)
- ❑ Colitis
- ❑ Depression
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Gastric Ulcer
- ❑ Gout
- ❑ Heart disease
- ❑ Hepatitis
- ❑ History of blood clots
- ❑ HIV/AIDS
- ❑ Hypertension
- ❑ Kidney disease/stones
- ❑ Lung disease/COPD
- ❑ Lupus
- ❑ Migraine
- ❑ MRSA
- ❑ Problems w/anesthesia
- ❑ Rheumatoid arthritis
- ❑ Thyroid disease

Other significant illness (please list): ______________________

FAMILY HISTORY

Have any direct relatives (mother/father/sister/brothers/children) had any of the following disorders? If so, who?

History	Relative	History	Relative	History	Relative
❑ Anesthesia Reaction		❑ Heart disease		❑ Osteoarthritis	
❑ Bleeding Disorders		❑ Hepatitis		❑ Rheumatoid Arthritis	
❑ Blood Clots		❑ Hypertension		❑ Thyroid Disease	
❑ Cancer		❑ Irregular heartbeat		❑ Ulcers	
❑ Diabetes		❑ Kidney Disease			
❑ Epilepsy		❑ Lupus			

Do any direct relatives have the same condition you are being seen for today? ❑ No ❑ Yes; who? __________

SOCIAL HISTORY

Do you use Tobacco? ❑ No ❑ Yes ❑ Past – How long ago? __________ if yes, how much? __________

Do you drink Alcohol? ❑ No ❑ Yes If yes, how often? ❑ Daily ❑ _____/week ❑ Other: __________

Do you use drugs for reasons that are not medical? ❑ No ❑ Yes If yes, please list: __________

Employment Status: Occupation? __________ Employer: __________

Employed: ❑ Full Time ❑ Part Time ❑ Self employed ❑ Disabled ❑ Retired **Student:** ❑ Full Time ❑ Part Time

Current work status? ❑ Full Duty ❑ Light Duty ❑ Not working due to this problem (How long? __________)

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other __________

Do you exercise? ❑ No ❑ Yes; 1-3 times/week ❑ Yes; 4 or more times/week ❑ Yes; active but no formal exercise

If yes, what type? __________ What Sports do you participate in? __________

SURGERIES

Description of surgery	Date	Results/Complications

Pharmacy of choice name, number and location:

____

DRUG ALLERGIES: ❑ No ❑ Yes To what? __________

Type of reaction: __________

Name: ______________________ (please print) Acct #: ______________ Dr: ____________

PRESENT MEDICATIONS INCLUDING OVER-THE-COUNTER:

Drug Name & Dose/Strength	Frequency or number of pills per day	Start Date?	Reason for taking
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

ACCIDENT / INJURY DETAILS

Date of accident/injury:______________________________

Current problem is the result of (check all that apply) ❑ Car Accident ❑ Work Accident ❑ Accident
❑ Other ____

Describe how your accident/injury occurred:____

____

Location of accident/injury was:____

Were you on the job or was it related to work? ❑ No ❑ Yes

If yes, Employer's name:______________________________Ph#:______________

Did you report it to your employer? ❑ Yes ❑ No If self employed, do you carry an accident policy? ❑ Yes ❑ No

If you were NOT in an auto accident, complete this section:

Did your injury occur on someone else's property? ❑ Yes ❑ No

Name and tel. # of property owner____

Adjustor Name______________________________ Phone #______________ Claim #______________

Complete this section if there was an auto accident:

I was: ❑ a driver ❑ a passenger ❑ a pedestrian

My auto insurance company is:____

Adjustor Name______________________________ Phone #______________ Claim #______________

Do you intend to make any claims other than Health Insurance? ❑ Yes ❑ No

Have you hired an attorney because of the accident? ❑ Yes ❑ No

Attorney Name ______________________________ Phone #______________

Attorney Address____

The information on this page is accurate to the best of my knowledge.

Patient's Name:______________________________ Signature:______________________________

Print Signature if Parent or Guardian (for minor)______________________________

TEXAS ORTHOPEDICS, SPORTS AND REHABILITATION ASSOCIATES

FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the office, we have adopted the following financial policy. If you have any questions, please discuss them with one of our patient collection specialists. We are dedicated to providing the best possible care to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- Payment is due at the time of service unless other arrangements have been made in advance. For your convenience, we accept cash, check, Care Credit and most major credit cards.

- Your insurance is an agreement between you and your insurance company. As a courtesy to you, we will file your insurance claims for you if you assign benefits to the physician. Your signature below authorizes the release of pertinent medical information to your insurance carrier(s). If your insurance company does not pay within a reasonable period, we will look to you for payment. If we later receive a check from you insurer, we will refund any overpayment to you.

- We have made prior arrangements with many health plans to accept an assignment of benefits. If you are covered by one of these plans, we will bill your plan and will only require you to pay the copayment, deductible, and/or coinsurance due at the time of service. Your signature below indicates you are assigning your insurance benefits to be paid directly to Texas Orthopedics for services rendered.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. We highly recommend that you READ YOUR INSURANCE BOOKLET or a copy of the contract your policy falls under to determine your benefits.

- You will be responsible for promptly responding to your insurance company to provide any additional information they may request regarding your treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in your account becoming due and payable, in full, immediately.

- Be prepared to present your insurance card and proof of identity (e.g. driver's license) at each visit. You will be responsible for providing a change of address, telephone number and/or insurance information any time a change occurs.

- A prepayment of your deductible and coinsurance will be required for your portion of our fees, based on our contract allowables, for scheduled surgical procedures and diagnostic testing. Any balance remaining after your health plan pays its portion is your responsibility and payment for this balance is due upon receipt of a statement from our office.

- Please be aware of the following medical records related fees: Medical Records copies-$15; CD of Images-$10; Printed Films-$8 per sheet; FMLA/Disability Forms-$15.

- We will look to the adult accompanying a minor for payment of all services rendered to minor patients.

When you are charged a "global" fee for surgery or office care of a fracture, laceration repair, excision of an ingrown toenail, etc., that fee not only includes the service on the day it is performed, but includes routine follow-up care as well. The global period ranges from 10-90 days depending on the procedure and your health plan. Injections, X-rays, and supplies (such as casting or dressing materials, splints, *braces, etc.) are not included in the "global" fee and a charge will be made for these items. Services related to complications are not included in the global fee.

***Please note there are no refunds or returns on all braces/soft goods.**

I have read and understand the financial policy outlined above, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by Texas Orthopedics.

______________________________	______________
Printed Patient Name	Date
______________________________	______________
Signature of Patient or Responsible Party if Minor	Date

Texas Orthopedics,
Sports & Rehabilitation Associates
www.txortho.com

Formulary Benefits Data Consent Form

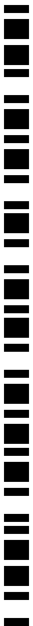
Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBMs are third-party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need access to your data as maintained by the PBMs to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan.

By signing below I give permission for Texas Orthopedics to access my pharmacy benefits data. This consent will enable Texas Orthopedics to:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers.



______________________________________ ________________
Patient Name (PRINTED) Date of Birth

______________________________________ ________________
Patient / Guardian Signature Date

Texas Orthopedics,
Sports & Rehabilitation Associates
www.txortho.com

From everyone at Texas Orthopedics, thank you for visiting us today and trusting us with your care. Our goal is to provide our patients with the best experience possible when interacting with our practice.

We are pleased to offer our interactive patient portal. It's secure, it's easy and it's convenient. With our patient portal, you can:

- Pay your bill
- Make appointment requests
- Request medical records
- Send secure messages
- Update your demographic information

Patient Name: ___________________________________

Email Address: ___________________________________

Check here if you do not have email. ☐

****Please note that your email will **ONLY** be utilized for the Patient Portal, and an occasional patient satisfaction survey.****

We are requesting the following information to be in compliance with the federal guidelines related to our electronic health record (EHR) system. The race and ethnicity classifications below are defined by the White House Office of Management and Budget.

Primary Language:

- ○ English
- ○ Spanish
- ○ Arabic
- ○ Chinese
- ○ Filipino
- ○ French
- ○ German
- ○ Greek
- ○ Hindi
- ○ Italian
- ○ Japanese
- ○ Korean
- ○ Polish
- ○ Portuguese
- ○ Russian
- ○ Vietnamese
- ○ Other
- ○ Decline

Race:

- ○ American Indian/Alaska Native
- ○ Asian
- ○ Black/African American
- ○ Native Hawaiian/Pacific Islander
- ○ Other
- ○ White
- ○ Decline

Ethnicity:

- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Decline

Lastly, we would like to confirm your personal settings for appointment reminders. Please indicate the best way for us to remind you of your upcoming appointments. By selecting one of the options below you are consenting to receiving our appointment reminders.

○ Email ○ Text ○ Phone (to number: ________________) ○ Declined (Do NOT send me reminders)

____ ____________________

Patient Signature Date