Patient Registration/Insurance

Patient: **Date:** ______________________

Name (first) ___________________________ (last) _____________________________ (middle) ______________________

Mailing Address ______________________________________ City _________________________ State_____ Zip _______

Email Address____ Preferred Language__________________________

Social Security # ____________________________ Date of Birth ____________________________ Marital Status _______

Home Phone: (   ) ___________________ Cell: (   ) _____________________Work: (   ) ___________________

Preferred Method of Contact: Phone_______ Cell_______ Email _______ Sex: Male___ Female ___

Race: (Circle One) American Indian/Alaskan Native White Black/African-American

Native Hawaiian/Pacific Islander Asian

Ethnicity: (Circle One) Hispanic/Latino Non-Hispanic/Latino

Occupation ______________________________________ Employer ____

Do you work: FULL TIME / PART TIME (Please circle one)

Emergency Contact ____ Phone (   ) ______________________________

Responsible Party: (if different than above)

Name (first) __________________________ (last) ________________________ Relationship to Patient _______________

Date of Birth _____________________________________ Social Security # ____

Mailing Address ______________________________________ City _________________________ State_____ Zip _______

Home Phone (   ) _______________________ Cell (   ) ______________________ Occupation__________________

Employer ____ Phone (   ) _______________________________________

Employer Address ____

Primary Insurance:

Company Name ______________________________ Effective Date______________________ Specialist Copay_________

Policy Holder: Name (first) _____________________________________ (last) ____________________________________

Date of Birth____________________________________ Relationship to Patient ____________________________________

Secondary Insurance

Company Name ____ Effective Date______________________________

Policy Holder Name:____ Date of Birth: ______________________________

Patient Medical History

Patient Name: ____ **Date of Birth** ____________________ **Date**___________________

Weight: ___________ Height: ___________ (feet) ___________ (inches)

Date of Injury ______________________ If no injury, date of onset _________________ Is the injury work related? ______________

Are you or is there any chance you might be pregnant? YES NO Last menstrual period: ___________________

Primary Care Physician: ____ Phone: ________________________________

Cardiologist ____ Phone: __________________________________

Referred by: ____ Phone: __________________________________

Do you have any drug allergies?------ Please list all Allergies and Reactions **Please Circle**

Medication ____________________________	Reaction ____________________________	MILD MODERATE SEVERE
Medication ____________________________	Reaction ____________________________	MILD MODERATE SEVERE
Medication ____________________________	Reaction ____________________________	MILD MODERATE SEVERE

Do you have a latex allergy? YES NO If yes, have you been tested? YES NO Date tested____________

Have you ever had a reaction to any kind of metal? (cheap earring, nickel, etc.) YES NO If yes, list reaction ______________

Medications (if able, please bring a copy of your list of medications)

List ANY medications, prescriptions with dosage, and over the counter medications you are taking; please include vitamins

____________________________	____________________________	____________________________
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________
____________________________	____________________________	____________________________

Social History

Do you currently or have you ever used tobacco products in the last 25 years? YES NO

If yes, what type? Cigarette Chewing Tobacco/Snuff E-Cigarette

Amount used daily? ________________________ Date you stopped using tobacco products __________________

Do you consume alcoholic beverages? YES NO Number of drinks daily? ________ Do you have a history of alcoholism YES NO

Patient Name: ____ **Date of Birth** _________________________ **Date**______________________

Please check any surgeries that you have had:

____Cancer Surgery
Type______________
____Angioplasty
____Cardiac Bypass
____Cardiac Stents
Year ____________
____Stents (other)
Type ____________
Date ____________
____Tonsillectomy

____Thyroidectomy
____Appendectomy
____Gallbladder
____Fem Pop Bypass RT Leg LT Leg
____Carotid Endarterectomy RT LT
____Cataract Removal RT LT
____Plastic Surgery ____________
____Hysterectomy
____Ovaries Removed
____Hemorrhoidectomy
____Tubal Ligation

____Breast Mastectomy RT LT
____Kidney Removed RT LT
____Kidney Stone Removed
____Prostate Removed (prostatectomy)
____T U R P
____Colon (Bowel Resection)
____Hernia Repair Type ______________
____Abdominal Aorta Aneurysm Repair

_____Other_____________________________

Please check any orthopedic surgeries:

____Shoulder RT LT Type of Surgery ____________________
____Elbow RT LT Type of Surgery ____________________
____Wrist/Hand RT LT Type of Surgery ____________________
____Hip RT LT Type of Surgery ____________________
____Knee RT LT Type of Surgery ____________________
____Foot/Ankle RT LT Type of Surgery ____________________
____Neck RT LT Type of Surgery ____________________
____Back RT LT Type of Surgery ____________________

Do you have a history of or currently being treated for the following: (Please check all that apply)

____Cancer/ Type-Specify
____
____Glaucoma
____Macular Degeneration
____Cataracts
____Asthma
____Tuberculosis
____Environmental Allergies
____COPD/Emphysema
____Sleep Apnea/CPAP
____CVA (stroke)
____TIA's
____Parkinson's Disease
____Seizures
____Migraines
____Fibromyalgia
____ADD/ADHD

____Alzheimer's
____Dementia
____Neuropathy
____Diabetes
____Thyroid Disorder
Hypo/Hyper
____HIV/Aids
____Hepatitis A B C
Year______________
____History of MRSA
Location_____________
Year________________
____Colitis
____Diverticulosis
____GERD (reflux)
____Hiatal Hernia

____Irritable Bowel Syndrome (IBS)
____ Stomach Ulcer
____Congestive Heart Failure
____Coronary Artery Disease
____High Blood Pressure
____High Cholesterol
____High Triglycerides
____Heart Attack
____Pacemaker
____A-Fib
____Defibrillator
____Heart Arrhythmia
____MVP
____Osteoarthritis
____Osteoporosis

____Osteopenia
____Rheumatoid Arthritis
____Gout
____Kidney Stone
____Kidney Disease
____BPH (enlarged prostate)
___Urinary Tract Infection
____DVT (blood clot)
____Carotid Artery Disease
____Blood Disorder
Type_______________
____Anemia
____Depression
____Anxiety
____Psoriasis
____Eczema

Please list any other medical conditions you are aware of: ____

Do you have any metal in the body? _________________ If Yes, Please indicate where; ____

Family Medical History: Please list any health problems your immediate family has been diagnosed with:

Medical Problem (Father)	**Medical Problem (Mother)**	**Medical Problem (Siblings)**
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

PATIENT NAME (PRINT): ____ DATE OF BIRTH: ___________________________

AUTHORIZATION

By signing this form, I consent to examination and treatment by a physician of Texas Hill Country Orthopedics and Sports Medicine P.A. I acknowledge the medical and demographic information I have given is true and accurate. I authorize you to obtain information pertaining to my treatment from other physicians including without limitation to any lab or diagnostic testing needed for treatment purposes.

X Signature: ____ **Date: ___________________________________**

FINANCIAL PAYMENT POLICY

Responsible Party (at least 18 years of age) must sign:

The undersigned hereby authorizes the release of any information to all claims for benefits submitted on behalf of myself and/or dependents. I further expressively agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered, or for services to be rendered without obtaining my signature on each and every claim to be submitted by myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Insurance is considered a method of reimbursing the doctor for services rendered, and not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and other insurance companies pay a percentage of the charge. It is my responsibility to pay the deductible amount, co-payments, co-insurance, out of network % and/or any other balance not paid by my insurance company, as applicable. **Payment is expected at the time services are rendered.**

I hereby understand the financial policy stated above.

X Signature: ____ **Date: ___________________________________**

Print Name: ____ **Relationship to Patient: _________________________**

RELEASE OF MEDICAL INFORMATION

I authorize the following people to have access to my medical information:

Name: ____ Relationship: _____________________________ Phone: _________________________

Name: ____ Relationship: _____________________________ Phone: _________________________

Name: ____ Relationship: _____________________________ Phone: _________________________

X Signature: ____ **Date: ___________________________________**

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with an opportunity to review (a copy if requested) of the Notice of Privacy Practices of Texas Hill Country Orthopedics & Sports Medicine P.A.

X Signature: ____ **Date: ___________________________________**

************************** **Employee Initials: _________________** **Date: ___________________** **************************