

# 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)

Local Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**Responsible Party: (if different then 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 \_\_\_\_\_ 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 ONLY the name of medications, prescriptions, 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:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Cancer Surgery<br>Type _____ | <input type="checkbox"/> Thyroidectomy                | <input type="checkbox"/> Breast Mastectomy RT LT          |
| <input type="checkbox"/> Angioplasty                  | <input type="checkbox"/> Appendectomy                 | <input type="checkbox"/> Kidney Removed RT LT             |
| <input type="checkbox"/> Cardiac Bypass               | <input type="checkbox"/> Gallbladder                  | <input type="checkbox"/> Kidney Stone Removed             |
| <input type="checkbox"/> Cardiac Stents<br>Year _____ | <input type="checkbox"/> Fem Pop Bypass RT Leg LT Leg | <input type="checkbox"/> Prostate Removed (prostatectomy) |
| <input type="checkbox"/> Stents (other)<br>Type _____ | <input type="checkbox"/> Carotid Endarterectomy RT LT | <input type="checkbox"/> T U R P                          |
| <input type="checkbox"/> Date _____                   | <input type="checkbox"/> Cataract Removal RT LT       | <input type="checkbox"/> Colon (Bowl Resection)           |
| <input type="checkbox"/> Tonsillectomy                | <input type="checkbox"/> Plastic Surgery _____        | <input type="checkbox"/> Hernia Repair Type _____         |
|   | <input type="checkbox"/> Hysterectomy                 | <input type="checkbox"/> Abdominal Aorta Aneurysm Repair  |
|   | <input type="checkbox"/> Ovaries Removed              |   |
|   | <input type="checkbox"/> Hemorrhoidectomy             | <input type="checkbox"/> Other _____                      |
|   | <input type="checkbox"/> Tubal Ligation               |   |

**Please check any orthopedic surgeries:**

- |   |   |
|---|---|
| <input type="checkbox"/> Shoulder RT LT Type of Surgery _____   | <input type="checkbox"/> Knee RT LT Type of Surgery _____       |
| <input type="checkbox"/> Elbow RT LT Type of Surgery _____      | <input type="checkbox"/> Foot/Ankle RT LT Type of Surgery _____ |
| <input type="checkbox"/> Wrist/Hand RT LT Type of Surgery _____ | <input type="checkbox"/> Neck RT LT Type of Surgery _____       |
| <input type="checkbox"/> Hip RT LT Type of Surgery _____        | <input type="checkbox"/> Back RT LT Type of Surgery _____       |

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

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Cancer/ Type-Specify _____ | <input type="checkbox"/> Alzheimer's                 | <input type="checkbox"/> Irritable Bowel Syndrome (IBS) | <input type="checkbox"/> Osteopenia                |
| <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Dementia                    | <input type="checkbox"/> Stomach Ulcer                  | <input type="checkbox"/> Rheumatoid Arthritis      |
| <input type="checkbox"/> Macular Degeneration       | <input type="checkbox"/> Neuropathy                  | <input type="checkbox"/> Congestive Heart Failure       | <input type="checkbox"/> Gout                      |
| <input type="checkbox"/> Cataracts                  | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Coronary Artery Disease        | <input type="checkbox"/> Kidney Stone              |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Thyroid Disorder Hypo/Hyper | <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> BPH (enlarged prostate)   |
| <input type="checkbox"/> Tuberculosis               | <input type="checkbox"/> HIV/Aids                    | <input type="checkbox"/> High Cholesterol               | <input type="checkbox"/> Urinary Tract Infection   |
| <input type="checkbox"/> Environmental Allergies    | <input type="checkbox"/> Hepatitis A B C             | <input type="checkbox"/> High Triglycerides             | <input type="checkbox"/> DVT (blood clot)          |
| <input type="checkbox"/> COPD/Emphysema             | Year _____   | <input type="checkbox"/> Heart Attack                   | <input type="checkbox"/> Carotid Artery Disease    |
| <input type="checkbox"/> Sleep Apnea/CPAP           | <input type="checkbox"/> History of MRSA             | <input type="checkbox"/> Pacemaker                      | <input type="checkbox"/> Blood Disorder Type _____ |
| <input type="checkbox"/> CVA (stroke)               | Location _____                                       | <input type="checkbox"/> A-Fib                          | <input type="checkbox"/> Anemia                    |
| <input type="checkbox"/> TIA's                      | Year _____   | <input type="checkbox"/> Defibrillator                  | <input type="checkbox"/> Depression                |
| <input type="checkbox"/> Parkinson's Disease        | <input type="checkbox"/> Colitis                     | <input type="checkbox"/> Heart Arrhythmia               | <input type="checkbox"/> Anxiety                   |
| <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Diverticulosis              | <input type="checkbox"/> MVP                            | <input type="checkbox"/> Psoriasis                 |
| <input type="checkbox"/> Migraines                  | <input type="checkbox"/> GERD (reflux)               | <input type="checkbox"/> Osteoarthritis                 | <input type="checkbox"/> Eczema                    |
| <input type="checkbox"/> Fibromyalgia               | <input type="checkbox"/> Hiatal Hernia               | <input type="checkbox"/> Osteoporosis                   |  |
| <input type="checkbox"/> ADD/ADHD                   |  |   |  |

**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 expressly 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:** \_\_\_\_\_ \*\*\*\*\*