

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	<input type="checkbox"/> Thyroidectomy	<input type="checkbox"/> Breast Mastectomy RT LT
Type _____	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Kidney Removed RT LT
<input type="checkbox"/> Angioplasty	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Kidney Stone Removed
<input type="checkbox"/> Cardiac Bypass	<input type="checkbox"/> Fem Pop Bypass RT Leg LT Leg	<input type="checkbox"/> Prostate Removed (prostatectomy)
<input type="checkbox"/> Cardiac Stents	<input type="checkbox"/> Carotid Endarterectomy RT LT	<input type="checkbox"/> T U R P
Year _____	<input type="checkbox"/> Cataract Removal RT LT	<input type="checkbox"/> Colon (Bowl Resection)
<input type="checkbox"/> Stents (other)	<input type="checkbox"/> Plastic Surgery _____	<input type="checkbox"/> Hernia Repair Type _____
Type _____	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Abdominal Aorta Aneurysm Repair
Date _____	<input type="checkbox"/> Ovaries Removed	
<input type="checkbox"/> Tonsillectomy	<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	<input type="checkbox"/> Osteopenia
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Dementia	Syndrome (IBS)	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/> Gout
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Congestive Heart	<input type="checkbox"/> Kidney Stone
<input type="checkbox"/> Asthma	<input type="checkbox"/> Thyroid Disorder	Failure	<input type="checkbox"/> BPH (enlarged prostate)
<input type="checkbox"/> Tuberculosis	Hypo/Hyper	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Urinary Tract Infection
<input type="checkbox"/> Environmental Allergies	<input type="checkbox"/> HIV/Aids	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> DVT (blood clot)
<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> Hepatitis A B C	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Carotid Artery Disease
<input type="checkbox"/> Sleep Apnea/CPAP	Year _____	<input type="checkbox"/> High Triglycerides	<input type="checkbox"/> Blood Disorder
<input type="checkbox"/> CVA (stroke)	<input type="checkbox"/> History of MRSA	<input type="checkbox"/> Heart Attack	Type _____
<input type="checkbox"/> TIA's	Location _____	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Anemia
<input type="checkbox"/> Parkinson's Disease	Year _____	<input type="checkbox"/> A-Fib	<input type="checkbox"/> Depression
<input type="checkbox"/> Seizures	<input type="checkbox"/> Colitis	<input type="checkbox"/> Defibrillator	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Migraines	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Heart Arrhythmia	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> GERD (reflux)	<input type="checkbox"/> MVP	<input type="checkbox"/> Eczema
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Osteoarthritis	
		<input type="checkbox"/> Osteoporosis	

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:** _____ *****