Patient Profile

Name: _____ **Date of Birth**:_____

Address: _____
(Street) (City) (State) (Zip)

Home #: ( ) _____ Work #: ( ) _____

Email: _____ **Contact By:** Email / Cell / Work Phone / Home Phone

Marital Status: _____ **Sex**: Female / Male SS #: _____

Referring Physician: _____ Phone Number: ( ) _____

Primary Care Physician: _____ Phone Number: ( ) _____

Language: _____ Race: _____ **Ethnicity:** Latino / NOT Latino / Decline

Next of Kin/Emergency Contact & Phone Number: _____

Patient Occupation: _____ (if retired, please state so)

Name of Employer: _____

INSURANCE INFORMATION: (If you have Medicare and a secondary insurance, inform the receptionist)

Insurance Carrier: _____ Member ID# _____

Name of Insured: _____ Relationship to the insured: Self / Spouse / Child / Other

Insured's Date of Birth: _____ Insured's Social Security #: _____

I authorize Orthopedic Specialists to release medical information that may be necessary to request reimbursement by my insurance company to whom I have submitted claims. I understand I am responsible for all medical fees during my treatment with Orthopedic Specialists. If surgery is required I assign all medical and or surgical benefits to include major medical benefits to which I am entitled to Orthopedic Specialists. This assignment will remain in effect until revoked by me in writing. A photocopy of assignment is to be considered as valid as an original. I understand that this office does not accept returns or issue refunds for any Durable Medical Equipment. I understand that all refunds for my account must be requested by myself or my guarantor, and may take up to 90 days to process.

In the event I should need surgery, I understand Dr. Charles E. Cook and Dr. John M. Noack are in partnership with a group of surgeons and Texas Health Resources in the ownership of Texas Institute for Surgery.

By signing below, I acknowledge that I have read the above information.

Signature: _____ Date: _____

Revised 5/10/18

Patient Form

Referral Source

How did you hear about us?

[] Physician/PA Referral [] Another Patient [] Web Search [] Insurance [] Athletic Trainer

[] Other: _____

Communication of Health Information

I hereby give permission to **Orthopedic Specialists** to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

_____

Name Relationship

_____

Name Relationship

_____**DO NOT** wish to give permission for family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how medical information will be used and disclosed. This includes the knowledge that all communications via email are not secure, and any information I send/receive is also not secure.

_____ _____

Patient Name Date

_____ _____

Signature of Patient/Representative Name of Representative (if applicable)

Revised 5/10/18

Financial Policy

Thank you for choosing our office as your health care providers. We are committed to providing excellent health care services. As part of our professional relationship, it is necessary that you have an understanding of our financial policy.

ALL PARENTS/PATIENTS MUST READ AND SIGN THIS FORM PRIOR TO RECEIVING ANY TREATMENT

- You understand and accept that it is your responsibility to:
  - Provide us with your current active insurance at every visit. Failure to do this may prevent this office from filing your claims to meet insurance timely filing deadlines, and you will be financially responsible for any services denied.
  - Provide us with your current billing and contact information. You may call us at any time to update this information.
  - Know and understand your contractual insurance benefits including if we are participating providers for your insurance plan.
- Copays, deductibles, and coinsurances are due at the time of services rendered.
- All fees collected at the time of service are estimates based on your plan benefits verified through your insurance, and you may receive additional charges or a credit after insurance has processed all claims.
- You will receive a statement (to the billing address you provide) notifying you of any balance due on your account. If you have any questions, it is your responsibility to contact our billing department within 30 days of receipt of your statement.
- Refunds can only be issued after your insurance has processed all outstanding claims, and may take up to 90 days to process.
- Failure to keep your account balance current may require us to cancel your appointment
- You will be charged a $25 Returned Check Fee for any checks that the bank returns unpaid for any reason as well as any credit card chargebacks.
- You may be charged a No Show Fee of $35 if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

WE ACCEPT CASH, CHECK, MASTERCARD, VISA, AND DISCOVER

By signing this form, you acknowledge you have read, understand, and accept this policy.

Guarantor Signature: _____ Date: _____

Revised 5/10/18

Patient Questionnaire

PATIENT NAME: _____ DATE: _____

Please describe the problem you are here for today: [] Left [] Right [] Foot [] Ankle (Please explain below)

_____

How long have you had the problem? _____ Date of Injury (if applicable) :_____

If it is an injury, how did the injury happen and where did it occur? _____

_____

Is this a work related injury? ___Yes ___No

Please check-mark the type of symptoms you have: (check all that apply)

[] Sharp [] Aching [] Stabbing [] Dull [] Cramping [] Throbbing [] Pins & Needles [] Numbness [] Constant [] Intermittent

On a scale of 1-10, how severe is the pain? No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

What makes it worse? _____

What makes it better? _____

Do you walk with an assistive device? [] Cane [] Crutches [] Walker

What physicians have you seen for this problem?_____ __

Did you bring: [] X-Rays [] MRI [] CT [] Bone Scan [] None

MEDICAL HISTORY: Please check any health issues that apply to you: [] No medical problems

[] AIDS/HIV	[] Cancer, breast	[] Gout	[] Childhood diseases
[] Alcoholism	[] Cancer, colon	[] Heart attack	[] Liver problems
[] Alzheimer's	[] Cancer, lung	[] High blood pressure	[] Bleeding problems
[] Anemia	[] Cancer, prostate	[] Hepatitis	[] History of infections
[] Rheumatoid arthritis	[] COPD	[] Kidney problems	[] Neuromuscular disorder(Parkinson's, etc.)
[] Asthma	[] Depression	[] Arthritis	[] Other heart problems
[] Blood clot leg	[] Diabetes, I or II	[] Seizures	
[] Blood clot lung	[] Drug abuse	[] Bleeding ulcers	
[] Stroke	[] Sleep apnea	[] Use of blood thinners	

Please describe any other health problems you have not checked in the above list: _____

_____

_____

Patient Questionnaire

PATIENT NAME: _____ DATE: _____

SURGICAL HISTORY: Please list any surgeries you have had in the past

_____

_____

Have you ever had general anesthesia? [] Yes [] No If yes, any Problems? [] Yes [] No

CURRENT MEDICATIONS: Please list prescription and over the counter medications

Name of Medication:	Dosage (example 10 mg.)	How often do you take it:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: _____

_____

FAMILY MEDICAL HISTORY: Please check any of the following family medical problems (immediate family)

[] Heart problems	[] Asthma/emphysema	[] Bleeding problems
[] Drug abuse	[] Psychiatric problems	[] Alcoholism
[] Stroke	[] Anesthesia problems	[] Tuberculosis

SOCIAL HISTORY: [] Employed [] Student [] Disabled [] Retired

Occupation: _____ Employer: _____

Do you smoke? [] Yes [] No If yes, how many per day? _____ If no, have you smoked in the past regularly? _____

Do you drink alcohol? [] Yes [] No If yes, how many drinks per week? _____

Do you get regular exercise? [] Yes [] No If yes, what type of exercise and how often?_____

Height: _____ (feet) _____ (inches) **Weight:** _____ (lbs) **Shoe Size**: _____

Check if you have any of the following: [] Dentures [] Glasses or contact lenses [] Hearing Aid

Patient Questionnaire

ONLY COMPLETE if you are **65 years of age or older**

Fall Risk Assessment

Please circle **YES** or **NO** for each statement below.

YES (3)	**NO**	I have fallen more than once in the past year.
YES (2)	**NO**	I have fallen once in the past year.
YES (2)	**NO**	I use or have been advised to use a cane or walker to get around safely.
YES (1)	**NO**	I sometimes feel unsteady or lose my balance when walking.
YES (1)	**NO**	I sometimes steady myself by holding onto furniture or walls.
YES (1)	**NO**	I need to push myself up from out of a chair with my hands.
YES (1)	**NO**	I sometimes have trouble stepping up onto a curb.
YES (1)	**NO**	I frequently have to rush to the toilet.
YES (1)	**NO**	I have lost some feeling in both of my feet.
YES (1)	**NO**	The medication I take sometimes makes me feel light headed or sleepy.
YES (1)	**NO**	I take medicine to help me sleep or improve my mood.
YES (1)	**NO**	I often feel sad or depressed.

_____ Total Add up the number of points from your circled answers.

If you scored **4 points or more,** you may be at risk for falling. Please discuss ways that may help prevent future falls with your physician.