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:

_____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 (Bowl 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
___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: _____** **********